REPRODUCTIVE HEALTH IN INDIA'S PRIMARY HEALTH CARE

CENTRE OF SOCIAL MEDICINE
AND COMMUNITY HEALTH
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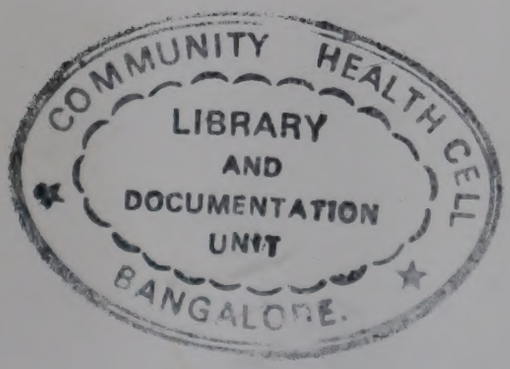

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Preface

Over the last decade, it has come to be increasingly accepted, albeit grudgingly, that the colossal family planning programme in India, arguably the largest such public health intervention in the world, has reached a dead end. Partly as a result of this realisation, partly as a result of the pressures generated by women's and health groups in the country calling for a radical reconsideration of the programme's goals and strategies, and partly in preparation for the third decennial International Conference on Population and Development (ICPD) at Cairo in 1994, the government of India appointed an Expert Group to chart out a new population policy for the country. While the *Report* of the Expert Group, submitted in May 1994, proclaimed a new orientation that was described as pro-poor, pro-nature and pro-women, it came under controversy for the manifest disjunction between its policy perspective and the policy recommendations that followed. Critics, largely and unanimously among women's groups, viewed it as merely lip service to the concept of gender equity. At the ICPD itself, a new approach to population policy was advocated in the Plan of Action, one which was not demographically driven but instead emphasised, on the one hand, the empowerment of women and, on the other, an approach of reproductive health care. It is in this context that the World Bank, whose commanding role in the health sector has reached an apogee in the last decade, brought out a document entitled *India's Family Welfare Programme: Towards a Reproductive and Child Health Approach* in June 1995 while the government of India, in enunciating a new reproductive health care (RHC) approach, visualises a paradigm shift in the family planning programme strategy.

Reproductive health has been defined as "a state in which people have the ability to reproduce and regulate their fertility; women are able to go through pregnancy and child birth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well being; and couples are able to have sexual relations free of the fear of pregnancy and of contracting disease".

While the broad aims outlined are incontestably laudable, there are nonetheless serious misgivings. In view of the chequered history of the development of health and family planning services in the country, the perceived limitations in the conceptual and epidemiological basis of the proposed changes, the fact that ICPD has seemingly marginalised the concerns of Third World women and the negative health consequences of larger macro-economic changes accompanying the RHC approach, debate has arisen among health groups and women's groups on the merits and weaknesses of this policy package.

In order to strengthen this discussion on the whole range of issues opened up by the newly initiated RHC approach, the faculty of the Centre of Social Medicine and Community Health of the School of Social Sciences of Jawaharlal Nehru University, New Delhi, organised a two-day national workshop entitled "The Place of Reproductive Health in India's Primary Health Care" on the 4th and 5th of November 1996. This workshop brought together public health scholars, clinicians, health and women's rights activists for wide ranging discussions.

The workshop generated intense and heated discussion and indeed some disagreement on priorities. There was however consensus on many issues. The first was the concern that India is apparently reneging on her commitment to provide free, universal and comprehensive primary health care. There could be no retreat on this front which could possibly be gender-sensitive. A gender sensitive RHC approach can only come about under the umbrella of a comprehensive PHC approach and cannot imply its dilution.

Second, there was a lack of reliable data underlying many health policy interventions in the past, especially those leading to vertical health programmes which had proved almost entirely ineffective; indeed this is also the case with the RHC approach. Without reliable data on the load of different diseases borne by the population, there is little epidemiological basis for a choice of intervention. In such cases, the choice is frequently based on the availability of technology or of other factors not necessarily linked to desirable health outcomes. The intervention chosen then makes little difference to the profile of morbidity and mortality and represents a waste of scarce community resources.

Third, and related to this, was of methodology: all too often morbidity data is considered to the exclusion of mortality data leading to distortions in priorities. Within morbidity studies, there is greater need for assessing the relational aspects of morbidity. In other words, the question to be asked is :given the overall morbidity load in a community, how significant is the burden of a particular disease?

The workshop, above all, drew attention to the complex of social, economic and political issues which both contour disease occurrence and the nature and content of health policy and intervention as well. In view of this, what is perhaps of overwhelming importance in a pro-people health agenda are issues of equity, including gender equity, in development.

Some of the papers presented at the workshop are included in this collection. I am deeply grateful to all the participants at the workshop, particularly those who wrote papers. I am also deeply grateful to UNFPA which modestly, and sans conditions, supported the workshop. The Committee on Women, Population and the Environment (CWPE), which has been working on the issue of reproductive rights in the West as much as of reproductive wrongs in Third World countries, also supported this project, equally modestly.

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Reproductive Health and Rights: A Public Health Perspective

IMRANA QADEER

Regulation and control of women's sexuality and reproduction are common to the history of all societies. Tribal wars over possession of women were rooted in the struggle for survival of the tribe itself. Later, women's skill and labour began to be valued as much as their ability to give birth. With the advent of machines, women also became the key to the maintenance of the labour that they reproduced. The control of women's fertility was thus considered necessary for both economic and social reasons. Studies of the 19th and early 20th centuries show how the institutions of religion, law and education were perfected as instruments of control. In the late 20th century, women-centred Family Planning Programmes (FPP) became the main instrument of such control as the emphasis on societal factors was gradually marginalised with demography emerging as a discipline.[1]

In contrast to the dominant social view, women themselves were concerned with the self-regulation of their fertility as also with their reproductive health. The women's movement, which emerged in the late 19th and early 20th century, took these up as part of "women's rights" issues and questioned the prevailing images and roles of women. It is important however to highlight the differences in the nature of demands that women made in different parts of the world. For instance, in the West, by the 1970s, social and economic conditions were ripe for women to assert their rights over their bodies, to demand the right to abort a foetus and be the sole decision-maker in the matter of having or not having a baby.[2] On the other hand, the women's movements in the Third World were linked with nationalist struggles against powerful political and economic forces. They asserted their entitlement rights, the right to equal wages and work. Although influenced by the Western women's movement, even in the post-70s, they focussed on marginalisation of women in the work force, the dwindling health and educational facilities of the public sector, rising prices, and the sexual exploitation of women.

This does not mean that issues of reproductive health were not relevant. It only reflects the fact that in their given conditions, a lot of ground work was necessary to be able to openly debate these highly sensitive issues and their links with the socio-economic and political fabric of society. Guided by the expressed demands of women, these movements concentrated on empowering women economically, politically, and socially[3] before they could question the deep

rooted assumptions of both women and men about reproductive rights.

There have been two very different reactions among western feminists to this basic difference in the content of women's movements in different parts of the world. One trend locates it in the political economy of health, rejects crude universalism, and attempts to seek explanations of women's reproductive and sexual health problems within their specific social situation.[4] It recognises the differences of approach within the feminist movement[5] and emphasises the significance of links between health and reproductive health as well as between structural adjustment programmes and women's empowerment.[6] The other trend highlights factors of commonality and emphasises strategies which place reproductive health centrally in dealing with women's health both at the policy level as well as within the women's movement.

It is within this context that this paper examines the concept of reproductive health as it emerged in the 80s, its consequences for health research and for the FPP in India. It also examines its advocacy for the Third World and the possible reasons behind it. We examine its epidemiological basis, and offer an alternative Public Health perspective for understanding reproductive health.

The need for such an exercise emerges in the light of two developments: first, the current shifts visible in the FPP where reproductive health assumes a new centrality. Second, the emergence of a school of thought that views reproductive health and rights as the central concern of women across the globe; it is then sought to make this the common minimum programme for all activists and policy makers in the area of women's health.[7]

The Concept of Reproductive Health

The 80s saw the emergence of a new perspective on family planning. Reacting to the emphasis on 'overpopulation' and the projection of women as "producers of too many babies", members of the International Women's Health Coalition focussed on the tendency to neglect other aspects of women's reproductive health. They argued that a reproductive health approach could strengthen existing family planning and health programmes as well as accrue dignity and basic rights to women. They identified as central issues the reallocation of resources among existing programmes, attention to reproductive health issues of women at all ages, the empowerment of women to manage their overall health and sexuality and encouraging their participation in policy making.[8] In other words, although the basic concern remained population growth (especially in the Third World) there was an attempt to change the strategy to deal with it.

The professed concern about the population problem was refined over time by invoking the feminist principle that every woman has the right to control her own sexuality and reproduction without discrimination. It was also argued that ensuring the highest possible level of reproductive health care is fundamental to the exercise of her reproductive rights. The concept now referred to a woman's capability to: (1) understand and enjoy her sexuality by gaining full knowledge of it; (2) regulate her fertility through access to services and information; (3) remain free of

reproductive morbidity (and death); and (4) bear and raise healthy children. The concept based itself on the belief that it "moves birth control out from under the umbrella of family planning and planned parenthood, with their patriarchal connotations, into the realm of individual rights to sexual and reproductive health."[9]

Reproductive health, then, was posed as an ideal, a dream to move towards; it obviously required different strategies specific to the varying social contexts prevailing in different parts of the globe. But this was possible only through recognising the interdependence of reproductive health, general health, and socio-economic conditions. Yet the actual concept of reproductive health failed to clearly articulate these linkages and their strengths.

Population: numbers versus needs

There have been some cosmetic attempts to fill in these conceptual gaps through the human development approach "within which reproductive health, empowerment and rights are central objectives". However, there are problems in this emphasis. Firstly, the advocates of this approach have not given up the notion of primacy of population numbers in development. Despite their full awareness of the scope of basic needs and the significance of "demand side" dynamics of livelihood and welfare, population control remained primary in working towards `sustainable development'. They defined population policy primarily as one of fertility control.

Secondly, structural issues if mentioned as factors in equitable and sustainable development, were never examined and targetted for intervention. The inevitability of a growth oriented globalised market economy was accepted while talking of issues of ethics, equity, human rights, and women's empowerment. As a result, the growing structural constraints on meeting popular demands were underplayed and fertility regulation was perceived as a point of convergence for feminists and environmentalists to mobilise support for a "population and family planning programme framed in the context of health and livelihood agenda".[10] Even when linkages were attempted, they were confined to health programmes alone.

Health against reproductive health

The replacement of the concept of 'women's health' by 'reproductive health' is yet another key contribution of the advocates of Human Development. Instead of visualising health issues as women of different regions see it for themselves, they merged them into a universal and homogenous reproductive health and rights agenda. As a consequence of their own priorities, they never really questioned either the epidemiological basis of reproductive health or the reasons behind women's manifest silence on reproductive health problems. Had they done so, the immensity of women's health problems and the social constraints on women's lives would have revealed the inappropriateness of their strategy in the context of the expressed needs of women asking for land rights, freedom from atrocities, food security systems, minimum wages, communal harmony and freesom from atrocities.[11]

Expansive traits

The all-pervasive nature of this concept of reproductive health has led to the incorporation of areas requiring interventions mainly outside the health domain in a new set of developmental strategies. Other than employment and education as empowering tools, reproductive health proponents now include areas such as nutrition and high foetal wastage due to industrial pollution and environmental degeneration.[12] The problem of undernutrition however, is intimately linked to agricultural policy, pricing, and the operation of the public distribution system. They may influence reproductive health but are not determined by it. Hence they are outside the arena of interventive strategies for R.H. Similarly, it is a well known fact that obstetric events are used as biological markers to assess environmental degeneration. Here again the answers lie outside the welfare domain, as was the case in Bhopal where women excessively suffered[13] the brunt of a callous industrial policy. Expanding the domain of a concept on the basis of symptomatology and not causes can only lead to a superficial and medicalised interventive strategy which cannot alter the real causes of reproductive ill health.

Supremacy of biological vulnerability

Despite all the emphasis on 'empowerment' and 'enabling conditions', the concept of reproductive health has derived heavily from the notion of the 'biological vulnerability' of women (who are in fact, biological the stronger sex) and the concept of "life cycle". This has brought about a subtle shift transforming the social process of bearing and rearing children into an essentially biological event. The notion of 'life cycle' compartmentalises women's lives, creates artificial disjunctures and places bio-demographic aspects above class and gender influences on health. In addition, it imbues the image of women with the instinctual and mindless existence of the invertebrates, de-emphasising their power to intelligently act upon and transform their own environment.

The neat divisions of the 'life cycle' approach can at best denounce social tragedies like child marriages, deaths of young women in child birth and the sexual exploitation or gynaecological suffering of widows. It cannot, however, explain them and therefore help change the situation since it fails to emphasise the continuity of exploitative processes begun in childhood which add on to the problems of various age groups. It is thus the ill-fed malnourished girl who becomes a sick, overworked, self-denying mother who then enters the post-reproductive phase, carrying a huge burden of ill-health. The life cycle approach, by identifying reproduction as the criterion for defining stages of life, actually medicalises it and undermines the social processes at work. This emphasis on common bio-demographic aspects runs against the face of the glaring differences in the maternal mortality rates between women of the first and the third worlds as well as between the rich and poor women within countries.[14]

Implications for praxis and theory

Having thus marginalised the role of socio-economic and political factors on the lives of women, the life cycle approach opens intimate spaces for intervention at two

levels - individual and at the level of the family. At the individual level, it is argued that the original definition of Maternal and Child Health is limited and that we need to broaden the scope and adopt a reproductive health approach on an ethical basis.[15] Thus the unfinished task of controlling maternal mortality is diluted further by expanding its scope of activity at a time when the resource crunch is actually weakening the infrastructure of health. It is not surprising then that as per the Model Registration data, deaths due to child birth have risen from 2.1 per cent of total female deaths to 2.9 per cent between 1982 to 1993. At the second level, the family rather than the social context within which it is located, becomes the arena of activity. Gender and reproductive roles are projected as purely intra-household events, and therefore, further dissociated from the macro socio-economic process.

This compartmentalised perception of family and reproduction performs an important theoretical function. It breaks the unity of production and reproduction in human societies[16] although the intimate links between the two have been established by several field studies.[17,18] As a consequence, such a schism prepares the ground for:

(a) Isolated activism, where empowerment can be granted through reproductive health activities alone. This was reflected in the series of women's meetings organised by international funding agencies in India before the ICPD and the Beijing Conferences. The focuss of discussion was reproductive health in its medicalised garb where reproductive tract infections, contraception, and AIDS became central. The issues of socio-economic influences and the links between general health and reproductive health were often missing.

(b) Ignoring the necessity of creating simultaneous cushions in the social sphere while intervening at the family level. The family as an institution in a patriarchal capitalist society is structured to absorb economic and social pressures generated outside it. Within the family, this is one of women's most significant functions. In traditional societies her self-perception has been assiduously nurtured to make her labour for 'love' and protect her dear ones. Any demand for help and support in performing her tasks or changing the nature of the task itself means shifting the power balance. In order to do this support must come either from within or from outside. Those who attempt to intervene from outside must also evolve external support systems and recognise the importance of simultaneous action at social and family levels. These support systems can be developed only when one takes up issues of entitlement, wages, work, and education which make women's assertion plausible not just for reproductive but social, economic, and political rights as well.

The Consequences

The conceptual problems inherent in the notion of reproductive health lend itself unproblematically to a range of interpretations depending upon ideological inclinations. This has consequences for the operationalisation of reproductive health, research, the articulation of needs and the strategies of the FPP.

Limited operationalisation

The Population Council experts, for instance, define it as the "prevention and management of unwanted pregnancies, services to promote safe motherhood and child survival, nutrition services for vulnerable groups, prevention and treatment of RTIs and STIs, reproductive health services for adolescents, health, sexuality and gender information, education and counselling and establishment of an effective referral system."[20] They thus transform reproductive health into a technologically determined gamut of services. It is inevitable therefore that the actual operationalisation further narrows the scope to contraception, maternal and child health, nutrition, services for RTIs and STDs, AIDS, abortions, and sterility.

This technological fix has been further narrowed down by the World Bank which sees family planning services alone as a necessary input to improve women's health. Hence fertility control largely become the key to a public health package.[21] The UNFPA, in a less commercial fashion, placed reproductive health of women centre stage and linked population, development, and environment to it.[22] Given its understanding that population growth is the main cause of poverty, women were identified as the central focus of intervention to reduce population and thereby, poverty.

These organisations used the terminology of reproductive health and, making use of its conceptual weaknesses, marginalised the social dimensions of empowerment. Helped by the life cycle approach which emphasised biological processes, the medicalisation of reproductive health became easy. Deprived of its social content, medicalised reproductive health can be as coercive as the previous FPP services.

Research

There has been a spurt of research activity with an emphasis on reproductive health. The international community has discovered as late as 1994 that contraception is also a need for Third World women. In the official family planning programme a need-based approach had been adopted as late as 1980s. Before this, however, no real effort was made to assess needs in India. The emphasis was on 'motivation' and 'education of target population' with the basic assumption that ignorance alone is the biggest barrier to the acceptance of the small family norm. Today huge funds are being invested by funding agencies to generate data on reproductive health. Organisations such as the Ford Foundation and the MacArthur Foundation are supporting social science research and interventive strategies to improve the reproductive health of women. The Ford Foundation, in its strategy paper for the 1990s, expresses its eagerness to invest in building institutional capacities for research in reproductive health, as it earlier did for demography. It proposes to propagate reproductive health research not only through social science and bio-medical institutions but also through non-governmental community-based organisations. The latter are seen as a means of direct intervention to promote reproductive health. Unlike formal institutions, they

are also less likely to have the "sociological orientation emphasising theoretical disciplines, and lacking implications for action".[23] The MacArthur Foundation, in its brochure, lists seven areas of research for which it provides financial assistance. Of these, only two touch the broader aspects of reproductive health and sexuality.

This thrust of the funding agencies has led to a perceptible shift from activism to research in the NGO sector. More and more of them are getting involved in training programmes for reproductive health and in generating "objective data" which is free from the shackles of contextualisation, be it the associated problems of illnesses of a general nature or the socio-economic and cultural constraints on women. Guided by the agencies' professional experts, the participating NGOs often adopt the given methodologies and conceptual framework. Those who ask questions or have alternative research designs arising out of their work experiences have problems getting support. Others feel exalted with the financial assistance and the proximity to power centres. The consequence is that reproductive health research does not arise either out of the perceived needs in women's lives or of epidemiological priorities.

Under the onslaught of funded research on reproductive health, studies which bring out the element of conscious choices that women make are few and scarce. Those which focus on women's strategies for livelihood are brushed aside as evidence of the culture of silence. Thus while the concept of reproductive health theoretically appropriates areas of welfare and development, actual women's demands for these are seen as suppression of reproductive health issues.

Universalisation of RH need

There is no denying the fact that the suppression of reproductive health and rights issues in the Third World is rooted in women's oppression under the exploitative patriarchal structure of the family that functions as the basic unit of the capitalist system. However, this reality is not sufficient to argue that reproductive health and rights issues of women in the First and the Third World can be treated at par.

This view tends to pay more attention to the middle class activist's views rather than the articulation of Third World working women themselves. While the latter struggle for a basic minimum livelihood, food, shelter and health for their families, the underlying unstated assumption of reproductive health advocates is that ordinary women, specially the poor, do not 'consciously' prioritise their basic needs.

A corollary to this is the vision that a population policy based on the principles of reproductive health empowers women to struggle for a better life. There are two serious lacunae in this view. First, it obfuscates the reality that women are constantly choosing between risks and adversities in their on-going struggle to minimise the strains of living, where these risks are a mix of social, reproductive, economic, psychological and health factors. This denial of women's ability to think and act for themselves within their given specificity is, in fact, counter productive and disempowering. It does not build on women's visions and their priorities but on a pre-conceived notion of what they ought to and need to do.

Secondly, this imposed strategy of empowerment does not take into account

the preparedness of women to assert their reproductive rights or the implications of such assertions on priorities and strategies of survival. Nor does it consider women's strength to cope with the tensions generated by such assertions in the absence of support from their spouses and families.

Two forces seem to have come together to push to the fore reproductive health and rights as a universal issue. One is the population lobby which has come to terms with the need to shed FFP's technocentric thrust and embrace a more subtle approach. The other is a section within the international women's movement which believes that a humane fertility control policy is possible within a neo-liberal economic framework that continues to push structural adjustment policies. Despite fully appreciating the conceptual and paradigmatic difference, this section proposes fertility control through reproductive health as the common minimum agenda for ideologically differing groups that are working for sustainable development.[24] Though they speak for unorganised poor women, they do not understand that a poor woman asking for a set of services when she meets a sympathetic listener is one thing, and asserting her independent rights for the same is quite another. The first does not call for restructuring survival strategies, the second demands this.

These two forces are thus pushing reproductive health centre-stage in the name of women's liberation irrespective of class and gender roles and thus the health, employment, and educational status of women.

Shifts in FPP strategies

A major consequence of this development has been the current reformulation of FPP strategies. Failing to adopt the "development is the best contraceptive" strategy proposed in the 70s, the programme had been groping for a less blatant but doubly effective means of population control. The pressure for achievements from the IMF and the World Bank, the fear of AIDS, the knowledge of links between AIDS and RTI, the availability of new contraceptives such as injectables, implants and quinacrine and the failure of past strategies of FPP coalesced to create conditions for the acceptance of a reproductive health strategy within the national FPP.

The new strategy expanded the scope of fertility control activities, maintained the pressure for achievement and yet appeared to have shifted out of the umbrella of the well recognised strategies of population control. Supported by international funding agencies at the ICPD at Cairo, the reproductive health strategy was accepted in principle without any discussion on development strategies or SAP. The basis of the shift was political rather than epidemiological. The little epidemiological data that existed was conveniently ignored and the shift in strategy was accepted by Third World countries in the hope that this will bring eagerly awaited foreign aid.

A Public Health Perspective

The reproductive health concept, as advanced both by the state and the aid agencies, focusses on fertility regulation rather than development. Its operationalisation into technocentric strategies rather than social and structural alternatives, its neglect of general health problems and its inability to confront the detrimental impact of structural adjustment policies on women make it amenable to appropriation by the population control lobby. This concept of 'reproductive health' is not necessarily pro-women, only women-centred. There is therefore a need to grasp the full complexity of the term 'reproductive health' and to put it in a public health perspective.

There is no denying the fact that the issue per se is an important aspect of women's health. However, the challenge is to define priorities within it according to the objective and subjective definitions of need, and to make it part of a larger developmental programme, based not only on equity of distribution but also on access and control of productive resources.

The subjective definition of reproductive health depends upon women's perceptions and articulations. Deeply rooted in the social matrix of each society, the actual expression of reproductive health needs depends upon the status and social position of women in it. Thus, it is not necessary that women would be in a position to articulate these needs especially in the Third World. This does not mean that till the women start articulating their needs, no interventions can be made. On the contrary, it calls for identifying the levels of intervention as well as evolving criteria for it.

Instead of looking at inter and intra-household relationships as two distinct sets of relationships as Dasgupta and Chen do[25] we need to understand power relationships between sexes within the socio-economic context which constantly impinges and alters power relations within families. This level of intervention is one which calls for social and political mobilisation to create conditions that make women's assertion of needs within families easier. It also calls for sensitivity towards their perception of needs and priorities.

In a milieu in which privatisation, social sector cuts, shrinking work opportunities and wages and dwindling food security systems are hitting women hardest, their basic survival needs cannot be given secondary status. The fact that women are being pushed back into the unorganised sector or into the boundaries of their homes to help families absorb the shock generated by a receding state makes them even more vulnerable. At the family and community level, therefore, the only way to tackle reproductive health issues is to locate them within the broader spectrum of needs as perceived by women.

At the policy level again, debate on health can be meaningful only if it addresses fully the socio-economic and political context of health (including reproductive health). In short, the adverse impact of structural adjustment policies (SAP) on the poor and especially women cannot be ignored. Even within the liberal framework of SAP with a 'human face', a population policy focussing on fertility control through the reproductive health approach cannot be considered sufficient unless it spells out its strategies for meeting people's basic needs.

Epidemiological priorities

Over the past few years there has been a spurt of literature on reproductive health. The field studies are either clinical or exclusively focus on women's reproductive health problems.[26,27] Although important, these reproductive diseases are not the only health problems of women. We examine here the mortality data from the Model Registration Scheme of the Government of India to get an idea of the reality. Two things need to be stated:

(a) The Model Registration Scheme has its limits as it is conducted through non-medical investigators, uses symptom complexes for a retrospective diagnosis and samples only PHC villages. Yet, it provides systematic information on causes of seven to ten thousand deaths annually.

(b) It has become a common argument that studying causes of deaths alone is not sufficient and that reproductive morbidities constitute a major hazard. Within a comprehensive public health perspective however, the link between morbidity and mortality should not be lost. Preventing deaths at times leads to higher morbidity levels, but lower morbidity with high death rates is not necessarily indicative of good health. Therefore when resources are limited, a judicious handling of the two, with a focus on those problems which lead to mortality first is an accepted methodology. Our assessment of data therefore will be within this perspective.

Table-I shows the total female deaths in India over the decade 1982-93 and highlights the very high proportion of mortality in the 0-4 years age group (22-28 per cent) as compared to the 5-14 year age group (4.7-5.4 per cent). While the highest mortality proportions in the age group 45 years and above is expected, the trend of rising proportions of deaths among 15-44 years over the decade (16-19 per cent) is a matter of concern. When we look at the main causes of death (Table-II), deaths due to child birth constitute 2.1 to 2.9 per cent of the total female deaths. The main causes of death remain respiratory diseases, causes peculiar to infancy, diseases of the circulatory system (which includes anaemias), fevers and digestive disorders. The notable trend is a lack of decline in proportions of those causes for which a specific programme exists, i.e., Maternal and Child Health.

To acquire a better idea of the distribution of causes, we have identified from each group specific communicable diseases. Deaths due to gastroenteritis, cholera, dysentery, tuberculosis, pneumonia, whooping cough, meningitis, jaundice, tetanus, chicken pox, measles and poliomyelitis have been clubbed together to look at three specific groups of causes of death viz. communicable diseases, maternity deaths (deaths related to pregnancy and child birth) and anaemias. Table-III presents age specific death rates for these three groups.

The important feature of this analysis is that in all age groups, communicable diseases cause the highest proportions of deaths. In the 15–44 years age group, these deaths are more than double the proportion of deaths caused by maternity. A finding of great concern is the stagnant maternal mortality trend although there is a

perceptible decline in the deaths due to communicable diseases. This decline must, however, be interpreted cautiously.

Table-IV provides the data on the distribution of communicable diseases over all age groups and shows the heavy mortality load it causes in the population 14 years or less of age. 47–53 per cent of all communicable disease deaths occur in young girls and 21-24 per cent in 15–44 year olds. The proportion of deaths due to communicable diseases in the reproductive age group has in fact increased after an initial decline. As a result the age-specific death rates for communicable diseases are much higher than the overall proportional distribution of deaths due to communicable disease (30:24 for 1993) in this age group. This proportion reverses to 40:49 in the younger group and to 12:35 in older women for 1993. Similarly, when we look at female deaths due to child birth alone (Table-V) we find that in the reproductive age group (divided into 15–24, 25–34 and 35–44 years), these deaths constitute not more than 17–19 per cent of the deaths due to communicable diseases except in 1993 where it is 24 per cent. This increase over time is perhaps due to complications of pregnancy related to rising communicable diseases (Table IV) and improved recording of maternal mortality. The poor recording of communicable diseases lately cannot also be completely ignored. Table VA, shows that communicable diseases continue to cause twice the number of deaths compared to maternal mortality, even if we confine ourselves to the 15–44 years age group. Put together, obstetric deaths constitute 1.7–2.9 per cent of all deaths in the 15–44 years age group and communicable diseases contribute 5.1 to 5.8 per cent of all deaths between 1988–93.

When we look at deaths due to anaemias in 15–44 years age group (Table-VI), we find that as a complication of pregnancy it has certainly declined as its share has come down from 3.4 per cent of all deaths to 1.02 per cent over 1982–93. However, general anaemia (without pregnancy) continues to be a serious threat to women's lives. Even if the 1993 figures are treated with caution, the rising contribution of general anaemia to deaths cannot be denied.

If we add to this the low levels of average calorie intake, as shown by the National Monitoring Bureau data, the picture of general health becomes very poor. For example, in nine major states, for 1975–78, the women who were sedentary workers (requiring 1900 calories) showed a mean calorie intake of 1307–1816 in all states except one. For women who were moderate workers also, all except one of the nine states had values less than the required 2200 calories and here too the range of mean intakes was 1141–1976.[28] This reflects the severe deprivation of adult women in Kerala, Tamil Nadu, Andhra, Maharashtra, Gujarat, M.P., West Bengal and Uttar Pradesh.

Links between maternal mortality and diseases

Women's poor nutritional status and the high prevalence of anaemias and communicable disease complicates reproductive health. This fact needs to be highlighted. Unfortunately very little recent national level data exists to demonstrate the association.

During the sixties however, the Ministry of Health and Family Planning published some useful statistics on this problem. For the years 1966, 1967 and 1968, we present cumulative data on deaths due to toxaemia, haemorrhages, complications of pregnancy, sepsis, abortion, and post-natal complications. Along with these we also have maternal (obstetric) deaths with associated medical conditions such as tuberculosis, anaemia, dysentery, and small pox. A majority of these were certified by doctors but some were not. We club this data in Table-VII, and find that among the total registered maternal deaths, up to 16.39 per cent of mortality is caused by complications due to associated causes. Given that all deaths were not certified by medical personnel, and complications such as cerebro-vascular diseases, diabetes, etc. have not been considered, the detection of associated causes can only be an under-estimate. Better diagnosis and services alone can help such women adequately. In other words, the under-estimation of the underlying ill-health of pregnant women is a major issue. Although such data is not available for the present, given the almost static levels of mortality and the return of epidemics of malaria, kalazar, hepatitis, plague, and dengue, grave doubts exist that the 90s present a more hopeful scenario.

The Model Registration data thus emphasises the following:

1. The importance of dealing with the health problems of girls under 15 years of age who bear the highest load of mortality and enter reproductive age with a disadvantage.
2. The importance of communicable diseases which not only kill the young but remain the major killers of women in the 15–45 years age group.
3. The inappropriateness of identifying reproductive age groups for intervention when communicable diseases, anaemias, and malnutrition are their major killers. These are problems common to all age groups.
4. The need to retain the focus on maternal mortality, and not to opt for broadening the base of MCH services, thereby diluting the available efforts as well the as resources of the public sector.
5. The need to recognise the impact of general illness on maternal health. The complications caused add to the maternal mortality. This data gives a clear basis for policy level interventions in the area of public health. It also perhaps partly explains the 'silence' of poor Indian women on the issue of reproductive health and rights.

Reproductive health as a component of primary health care

Despite the above evidence, the increasing emphasis by reproductive health advocates on AIDS, STD, RTIs, abortion and contraception has pushed open the scope of maternal and child health without actually completing the task of bringing down maternal mortality to acceptable levels. This broadening of the scope of MCH therefore may either lead to diluting the emphasis on reducing maternal deaths or demand diversion of Primary Health Care resources to reproductive health. The original definition of MCH as conceived by the WHO adequately included the additional dimensions which are today being included as "new". It also emphasised

the importance of dealing with associated health problems, especially communicable diseases.[29] Concerted efforts to lower maternal mortality through the provision of preventive and emergency maternity services and the efficient working of all national health programme therefore continues to be the primary need of women.

For this, adequate referral services at the Community Health Centre level—and not the private sector as advocated by the World Bank—must be made mandatory as the majority of women who need help can only depend upon the public sector. This is evident from the NSS data on utilisation of indoor services.[30] A critical input, which the services have not as yet acquired, is the long promised obstetric and gynaecological specialist at the CHC with basic minimum infrastructure. Such a facility will not only deal with obstetric problems but also the RTIs, STDs and gynaecological problems which may need intervention (including abortion services).

A review of expenditure over the 90s reveals that the actual investments follow a trend which neither shows a strengthening of MCH services nor indicates any significant shifts towards the better in communicable diseases control programme investments (Table VIII).

The central government expenditures place much more emphasis on family welfare than on public health. This relatively higher input into FPP is evident from the grand totals given in Table VIII and IX. The budgets for FPP have risen by 30 to 40 per cent over the years. The investment into MCH over 1982–93 declined in proportion. Inputs into supportive programmes such as the Post Partum Programmes and the Community Health Guide Schemes have remained unchanged or have actually declined. From 17 per cent of the budget, the investment into these three activities have declined to about 12 per cent, with MCH investments remaining under 1982 proportions. This means that despite all the rhetoric the real emphasis continues to be on contraceptive and sterilisation services.

Similarly, the health budget's proportionate inputs into public health (Table IX) shows drastic cuts over 1990–92. The apparent improvement in the later years is actually due to the investment in kalaazar and plague epidemics and increase in the Blindness Control Programme allocations (1994–95). If for example, the 80 crores invested into these programmes are deducted from 1994–95 expenditure on public health, the proportion of investment falls to 35 per cent. The only communicable diseases control programmes where there is a significant improvement in the proportion of investment are the ones for leprosy and AIDS. The tuberculosis programme shows a marginal increase in its share (from 7 per cent to 10 per cent) while malaria and filaria get the maximum share of cuts.

Despite these obviously distorted patterns of funding, it has been argued that financing reproductive and sexual health services is critical for the Third World. Having first advocated a broad-based health and development-oriented concept of reproductive health, the experts eventually narrow it down to medical services for STD, AIDS, abortion, MCH, maternal malnutrition, in addition to contraception, which according to them, has received too much attention. They propose household surveys to assess reproductive health budgets at the family level. The donors too are

urged to play a key role in financing reproductive health services, even if they form only 3 per cent of the national health and family welfare budget in the Third World countries.[31]

From a public health perspective then, the cuts in the health budget and the stagnation in MCH services, along with an unflinching emphasis on contraceptive services, FPP infrastructure and AIDS, does not augur well for women's health. Two things are clearly needed. First, that within reproductive health, priorities should be clearly articulated and reflected in the budgetary allocations. Second, that MCH, nutrition, contraceptive services and communicable disease control must be integrated. This alone can give optimal results not just for reproductive health but for women's health as a whole.

The issues of women's health (including reproductive health), we have argued, goes well beyond the domain of the public sector in health. Woven into the fabric of society, it is open to intervention at different levels. Policy, welfare programmes, training activitties and community level mobilisation can influence it deeply. It is therefore incumbent upon those who choose to intervene that they should grasp the limits and complexities of the levels at which they intervene. The blurring of this matrix can otherwise create an illusion of achievements where none exist.

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Table-I: Total Female Deaths in India, 1982-93

Age groups	*1982*	*1983*	*1984*	*1985*	*1986*	*1988*	*1989*	*1990*	*1991*	*1992*	*1993*
0-4	2000 (28.05)	2065 (26.62)	2113 (26.74)	2080 (27.01)	2155 (26.32)	2546 (24.76)	2309 (24.32)	2055 (22.39)	2274 (22.68)	2680 (23.56)	3258 (24.51)
5-14	368 (5.16)	392 (5.05)	412 (5.21)	391 (5.08)	426 (5.20)	510 (4.96)	452 (4.76)	472 (5.14)	544 (5.43)	551 (4.84)	654 (4.92)
15-44	1168 (16.38)	1340 (17.27)	1300 (16.45)	1319 (17.12)	1414 (17.27)	1603 (15.59)	1724 (18.16)	1661 (18.09)	1770 (17.66)	2144 (18.85)	2543 (19.13)
>45	3593 (50.40)	3961 (51.06)	4077 (51.59)	3912 (50.79)	4192 (51.20)	5624 (54.69)	5009 (52.76)	4992 (54.38)	5437 (54.23)	5998 (52.74)	6836 (51.43)
Total	7129	7758	7902	7702	8187	10283	9494	9180	10025	11373	13291
Total deaths in age <15 yr.	4761	5301	5377	5231	5606	7223	6733	6653	7207	8142	9379
% of total deaths	66.78	68.33	68.04	67.91	68.47	70.28	70.92	72.47	71.89	71.59	70.56

Source: Survey of causes of death (Rural), RGI, Vital Stat. Division
Figure in parenthesis represent percentages.

Table-II: Percentage of Deaths Among Major Cause-Group by Female in India 1982–1993

	Major Causes	*1982*	*1983*	*1984*	*1985*	*1986*	*1988*	*1989*	*1990*	*1991*	*1992*	*1993*
1.	Accidents & injuries	4.4	4.6	4.9	5.1	6.0	5.5	6.4	7.5	7.7	7.1	6.82
2.	Child-birth & Pregnancy	2.4	2.6	2.2	2.7	2.1	1.8	2.1	2.3	2.5	2.4	2.93
3.	Fever	10.4	10.8	10.7	9.9	11.0	8.8	8.2	8.2	7.9	8.5	7.35
4.	Digestive Disorders	7.4	7.8	7.8	7.6	7.7	6.8	6.9	6.8	6.7	6.9	7.22
5.	Cough (Disorders or Res. System)	17.2	18.0	18.2	18.8	17.6	18.6	18.3	16.3	16.3	17.2	16.15
6.	Disorders of the Cent. Nervous system	3.5	4.5	3.9	3.9	4.6	4.6	4.6	4.3	4.4	4.3	4.25
7.	Disease of Circulatory system	7.4	8.5	9.1	9.1	8.3	8.4	9.8	9.7	9.8	9.3	9.67
8.	Other clear symptoms	8.2	7.4	7.6	8.8	8.8	8.7	8.0	8.0	7.9	7.9	8.26
9.	Causes peculiar to infancy	12.4	11.2	10.8	10.7	10.2	10.1	9.8	9.9	10.7	10.2	11.74
10.	Senility	24.8	24.2	24.2	23.4	24.4	26.1	26.0	27.1	26.1	26.2	25.61

Source: Survey of causes of death, GOI, 1982–1993.

Table-III: Age Specific Deaths (female) due to Specific Causes

Age Group		1982	1983	1984	1985	1986	1988	1989	1990	1991	1992	1993
0-4	Comm. Dis	1079 (45.56)	1112 (45.26)	1201 (47.56)	1151 (46.58)	1236 (47.89)	1478 (48.36)	1286 (46.55)	1076 (42.58)	1185 (42.05)	1223 (37.85)	1600 (40.90)
	Mat. Death	1	–	–	–	–	–	–	–	–	–	–
	Gen. Anaemia	34 (1.44)	96 (3.91)	98 (3.88)	117 (4.73)	132 (5.11)	151 (4.94)	125 (4.52)	148 (5.85)	137 (4.86)	152 (4.70)	198 (5.06)
	Total female deaths in the age sp.	2368	2457	2525	2471	2581	3056	2761	2527	2818	3231	3912
15-44	Comm. Dis.	443 (37.93)	489 (36.49)	470 (36.15)	473 (35.86)	504 (35.64)	532 (33.19)	545 (31.61)	490 (29.50)	497 (28.08)	624 (29.10)	775 (30.48)
	Mat. Death	161 (13.78)	200 (14.92)	175 (13.46)	241 (18.27)	176 (12.45)	182 (11.35)	202 (11.35)	209 (12.58)	251 (14.18)	270 (12.59)	384 (15.10)
	Gen. Anaemia	24 (2.05)	52 (3.88)	56 (5.15)	44 (93.34)	49 (3.47)	69 (4.30)	75 (4.35)	58 (3.49)	69 (3.90)	95 (4.43)	135 (5.31)
	Total female deaths in the age groups	1168	1340	1300	1319	1414	1603	1724	1661	1770	2144	2543
45+	Comm. Dis.	486 (13.52)	615 (15.53)	576 (14.13)	601 (15.36)	611 (14.58)	726 (11.04)	553 (11.04)	517 (11.96)	680 (12.50)	732 (12.20)	820 (12.00)
	Mat. Death	6	6	4	–	–	–	–	–	–	–	–
	Gen. Anaemia	143 (3.98)	172 (4.35)	196 (4.8)	162 (4.14)	129 (3.08)	145 (2.58)	168 (3.35)	148 (2.96)	159 (2.92)	149 (2.48)	181 (2.65)
	Total female deaths in the age group	3593	3961	4077	3912	4192	5664	5009	5992	5437	5998	6836

Figures in parenthesis represent percentages of age specific deaths due to that cause.

Source: Survey of causes of death, GOI Reports

Table-IV: Percentage Distribution of Female Deaths Due to Communicable Diseases in India, 1982–93

Age groups	*1982*	*1983*	*1984*	*1985*	*1986*	*1988*	*1989*	*1990*	*1991*	*1992*	*1993*
0-4	43.22	38.74	42.90	42.06	41.59	42.10	43.28	38.0	37.0	38.69	38.94
	(868)	(860)	(964)	(936)	(978)	(1152)	(1032)	(823)	(874)	(994)	(1244)
5-14	10.50	11.35	10.54	19.66	10.97	11.91	10.65	11.70	13.16	8.92	11.14
	(211)	(252)	(237)	(215)	(258)	(326)	(254)	(253)	(311)	(229)	(356)
15-44	22.06	22.03	20.91	21.25	21.43	19.44	22.86	22.65	21.04	24.29	24.26
	(443)	(489)	(470)	(473)	(504)	(532)	(545)	(490)	(497)	(624)	(775)
>45	24.20	27.70	25.63	27.01	25.98	26.53	23.19	27.6	28.78	28.50	25.67
	(496)	(615)	(576)	(601)	(611)	(726	(553)	(597)	(680)	(732)	(820)
Total Deaths	2008	2216	2247	2225	2351	2736	2384	2163	2362	2569	3195
	(28.1)	(28.5)	(28.4)	(28.8)	(28.7)	(26.6)	(25.1)	(23.6)	(23.5)	(22.5)	(24.0)

Source: Survey of causes of death—rural GOI, 1982–1993.
Figures in parenthesis represent deaths in absolute number.

Table-V: Female Deaths due to Child Birth in India

Age	*1982*	*1983*	*1984*	*1985*	*1986*	*1988*	*1989*	*1990*	*1991*	*1992*	*1993*
15–24	56 (6.03)	95 (8.57)	66 (5.96)	70 (6.52)	79 (7.09)	68 (5.40)	72 (6.56)	92 (7.39)	87 (7.39)	112 (8.32)	128 (8.02)
25–34	70 (7.53)	66 (5.96)	79 (7.12)	76 (7.07)	67 (6.01)	84 (6.68)	96 (8.74)	95 (8.74)	106 (9.01)	114 (8.47)	187 (11.72)
35–44	35 (3.77)	39 (3.52)	30 (4.71)	54 (5.03)	30 (2.69)	30 (2.38)	34 (2.38)	21 (1.93)	58 (4.93)	43 (3.19)	69 (4.31)
>45	6 (0.65)	6 (0.54)	1 (4.71)	8 (0.74)	–	–	–	2 (0.18)	–	–	–
Total	167 (17.98)	206 (18.59)	176 (15.88)	208 (19.37)	176 (15.78)	182 (14.47)	202 (18.40)	210 (19.32)	251 (21.32)	269 (19.59)	384 (24.08)
Total death due to major Comm. disease in the age group 15 years	929	1108	1046	1074	1115	1258	1098	1087	1177	1346	1595

Source: Survey of causes of Death - GOI, 1982–1993.
Figures in parenthesis are death as percentage of deaths due to communicable diseases in 15 yr.

Table-VA: Relative Proportion of Maternal and Communicable Disease Deaths in 15-44 Yr. Age Group

Years	*1982*	*1983*	*1984*	*1985*	*1986*	*1988*	*1989*	*1990*	*1991*	*1992*	*1993*
Mat.Mort.	161	200	175	200	176	182	202	208	251	296	384
	(2.24)	(2.57)	(2.21)	(2.59)	(2.15)	(1.77)	(2.13)	(2.26)	(2.50)	(2.36)	(2.89)
Comm. Dis.	443	489	470	473	504	532	545	490	497	624	775
	(6.21)	(6.30)	(5.95)	(6.14)	(6.16)	(5.17)	(5.74)	(5.34)	(4.96)	(5.49)	(5.83)
Total female deaths	7129	7758	7902	7702	8187	10283	9494	9180	10025	11373	13291

Figures in parenthesis represent percentages from total deaths.
Source: Survey of causes of death (rural), RGI, Govt. of India.

Table-VI: Distribution of Deaths Due to Anaemia with and Without Pregnancy Among Women Aged 15-44 Years

	1982	*1983*	*1984*	*1985*	*1986*	*1988*	*1989*	*1990*	*1991*	*1992*	*1993*
Anaemia with preg.	40 (3.42)	37 (2.46)	41 (3.15)	42 (3.18)	30 (2.12)	31 (1.93)	41 (2.38)	41 (2.46)	50 (2.82)	53 (2.47)	26 (1.02)
Gen. Anaemia	24 (2.05)	52 (3.88)	67 (5.13)	44 (3.34)	49 (3.34)	69 (4.30)	75 (4.35)	58 (3.49)	69 (3.90)	95 (4.43)	135 (5.31)
Total	64	89	108	86	79	100	116	99	119	148	161

Source: Survey of causes of death, GOI.
Figures in parenthesis are percentages.

Table-VII: Distribution of Maternal Deaths by Obstetric Causes Direct and Associated with General Diseases

Year	*Direct Obstetric Mortality*			*Indirect Obstetric Mortality*			
	Certified by doctor	*Not certified by doctor*	*Total*	*Certified by doctor*	*Not certified by doctor*	*Total*	*Grand Total*
1966	49672 (92.79)	3858 (7.20)	53530 (89.17)	5898 (90.69)	605 (9.30)	6503 (10.83)	60033
1967	51925 (94.08)	3265 (5.91)	55190 (87.30)	7658 (95.37)	371 (4.62)	8029 (12.70)	63219
1968	44680 (96.96)	1397 (3.03)	46077 (83.61)	8599 (95.17)	436 (4.82)	9035 (16.39)	55112

Figure in parenthesis indicate percentages.

Source: Health Statistics of India, 1966 to 1970, DGHS, Ministry of Health and Family Planning, Government of India, New Delhi.

Table-VIII: Annual Expenditure on Family Welfare

Family Planning Expenditure						
Year	*89-90*	*90-91*	*91-92*	*92-93*	*93-94*	*94-95*
MCH	72.45 (11.23)	88.60 (11.15)	99.60 (11.49)	95.25 (9.06)	125.24 (9.75)	151.59 (10.51)
PPP	22.00 (3.41)	28.25 (3.55)	28.25 (3.25)	50.30 (4.78)	49.65 (3.86)	49.47 (3.43)
Vol sect.	5.4 (0.84)	5.34 (0.67)	5.80 (0.67)	6.97 (0.66)	10.06 (0.78)	8.80 (0.61)
CHG	18.00 (2.79)	50.00 (6.29)	24.00 (2.77)	21.00 (2.00)	21.00 (1.63)	10.00 (0.69)
Grand Total	645.04	794.72	866.60	1051.41	1284.91	1442.03

Source: Expenditure budget 1989-90 to 1995-96, vol.II, Govt. of India.
Figures in parenthesis are column percentages
The figures do not add up to the total as expenditure on FP services such as FW Centres, compensation area projects, CC distribution, transport etc. have not been noted.

Table-IX: Annual Expenditure on Health

Year	*89-90*	*90-91*	*91-92*	*92-93*	*93-94*	*94-95*
CGHS	50.26 (11.66)	63.07 (13.16)	67.32 (12.81)	79.46 (10.82)	107.72 (12.76)	120.00 (12.07)
Hosp. Disp	33.80 (84)	39.75 (8.29)	48.02 (9.14)	70.25 (9.57)	75.11 (8.90)	81.14 (8.16)
Med. Ed. Training & Research	147.16 (34.14)	171.93 (35.86)	180.03 (34.27)	239.24 (32.59)	260.75 (30.90)	293.84 (29.56)
Other systems of med.	18.41 (4.27)	22.1 (4.61)	21.99 (4.19)	29.01 (3.95)	33.62 (3.98)	39.09 (3.93)
Public Health	164.23 (38.10)	165.19 (34.45)	179.41 (34.15)	291.82 (39.74)	346.90 (41.10)	431.78 (43.44)
Other progs.	9.15 (2.12)	8.28 (1.73)	19.13 (3.64)	11.50 (1.57)	5.95 (0.71)	12.46 (1.25)
Grand Total	431.00	479.42	525.31	734.15	843.94	993.89

Source: Expenditure budget 1989-90 to 1995-96, vol.II, Govt. of India.
Figures in parenthesis are percentages
The figures do not add up to the total as expenditure on public enterprises, DGHS, etc. have not been noted.

Reclaiming the Reproductive Rights Agenda: A Feminist Perspective

T.K. SUNDARI RAVINDRAN

Reproductive Rights and Reproductive Health

Reproductive rights has for long been on the agenda of feminist movements across the globe. The birth control movement which emerged in the first and second decades of the present century was essentially a protest movement of women. In 1918, the National Union of Women's Suffrage Societies in England expanded its objectives to include legislative reforms in various fields like divorce and legitimacy, and also pressed for both voluntary and public birth control provision. Many women's organisations in England, including women workers' organisations, supported the movement because they were concerned with the high rates of maternal mortality and wanted to free women from the bondage of unwanted pregnancies. In 1915, Emma Goldman and Margaret Sanger deliberately defied obscenity laws in the US by distributing pamphlets on birth control, and initiated the movement there. And even earlier, in 1908, Alexandra Kollantai in her *Social Bases of the Women Questions* claimed not only women's rights to fulfilling work but also their rights to sexual freedom and control over their own fertility.[1]

The rise of the feminist movement in the West in the 1960s again brought reproductive rights issues to the forefront. The demand for reproductive rights soon became global, consequent to the realisation that despite substantial differences in their lives in different settings, women around the world generally lacked control over their bodies, their sexual lives, their reproductive decisions, their health.[2] External control over women's bodies was through patriarchal ideology within the family and community on the one hand, and state policies on the other. Demographically driven population control policies; pronatalist policies which restricted access to contraception; restriction of abortion in many countries of the world; criminalisation of homosexuality in some country settings—these are only some examples.

Organised efforts by the feminist movement in the 1970s demanded changes in legislation, policies, programmes and services affecting many areas of women's reproductive health—abortion, birth control, sexual self-determination, shelters for battered women, rape crisis centres. Services to meet women's needs and set up by women appeared in many parts of the world.

These campaigning and service-delivery experiences over nearly two decades have influenced policies in many countries to make these more women-centred and

gender sensitive, with varying degrees of success. A dynamic women's movement supported by a favourable political climate, succeeded in some countries in putting in place women's health policies with reproductive and sexual health constituting their core. Brazil, Australia, Columbia in the 1980s, and more recently, South Africa are notable examples.

However, reproductive health issues were suddenly elevated to centre stage by the media and by international agencies when the ICPD Programme of Action focused centrally on these issues. It may be useful to recall at this historical juncture that the demand for reproductive rights and health did not originate in Cairo, and that it is not an original idea formulated by population control agencies or international agencies that have supported them.

The women's movements' definition of reproductive rights has evolved over the years, and is now generally understood as the right of women to:

- regulate their own fertility safely and effectively, by conceiving when desired, terminating unwanted pregnancies, and carrying wanted pregnancies to term;
- bear and raise healthy children;
- remain free of disease, disability, fear, pain or death associated with reproduction (and the reproductive system) and sexuality.

Reproductive health is thus seen as a part of women's reproductive rights. Reproductive health services is an essential part, but not the whole, of the package of interventions and policies necessary for the promotion of women's reproductive health. The idea that health is a development issue is a well-known one. Reproductive health is similarly, a 'women's empowerment' and 'gender equity' issue.

Many of women's reproductive health problems originate from gender inequities and from the limited responsibility men take for the consequences of their sexuality and fertility. For example, early marriages followed by adolescent pregnancies which carry a high risk of morbidity and mortality, signify women's lack of control over choice of their sexual partners and over the spacing and number of children. Unwanted pregnancies, back-street abortions, and sexually transmitted diseases (including HIV/AIDS) in most women are often the consequence of the male partners' less than responsible sexual behaviour. Again, women alone bear the burden of contraception in the vast majority of cases.

There are two important enabling factors underlying women's reproductive health: *power* and *resources*. For women to enjoy good reproductive health, then, they need the power to make decisions and to have control over their bodies and their lives. More importantly, they need access to resources that will enable such a choice: individual resources such as education and economic independence, and household and community resources such as fulfilment of basic needs and access to basic infra-structural facilities.[3]

Is not a focus on reproductive health antithetical to the feminist struggle for recognition of women as 'more than reproducers'? On the contrary, the demand for reproductive health is part of women's struggle not to be

subordinated or controlled as a consequence of their biological role as bearers of children. In the absence of means to control or regulate their fertility, women's very lives are dominated by their role in biological reproduction. They suffer social and economic disadvantages because of their sole responsibility for child care. Women's mobility is restricted because they run the 'risk of being impregnated', and their sexuality controlled through the threat of an unwanted pregnancy.

The focus on reproductive health has been criticised in some quarters as being too narrow, and that it is important to talk instead about 'women's health'. A demand for 'basics' has never meant that other needs are unimportant. There is no doubt that reproductive health is only one component of women's health concerns, but a very significant one nevertheless. Denial of women's right to better reproductive health through policies and programmes (implicit or explicit) that take control of their bodies away from women is a political issue. It is not merely a question of the absence of a few essential components or one of better standards of care. The priority to be accorded to reproductive health cannot therefore be assessed merely in terms of number of lives lost or morbidity suffered by women from causes related to reproduction.

> Reproductive health is not now, and never has been, simply a matter of preventing disease. This is because women's ability to bear children is linked to the continuity of families, clans and social groups; the control of property; the interaction between human communities and their environment; the relationship between men and women; and the expression of sexuality. It is therefore valuable currency in every society and the object of regulation by families, religious institutions and governmental authorities.[4]

It is against this backdrop that this paper seeks to outline some basic principles and strategies for a reproductive health programme guided by the principles of gender equity and women's empowerment.

Basic Principles and Strategies for a Reproductive Health Programme

Health problems of Indian women arise from a complex combination of factors, including poverty and inequality affecting men and women alike, as well as disadvantages arising from undervaluation of women in a patriarchal social setting: neglect of the female child, nutritional inadequacies, illiteracy, limited access to resources, low self-esteem and lack of decision making power. These combine to aggravate the health risks associated with sexuality and reproduction, and result in the high mortality rates and chronic low grade morbidity for women.

Reproductive health concerns of women in India (as elsewhere) are a product of the social milieu, and need more than medical solutions. It would be futile to attempt to deal with these adequately and with any measure of success, through a mere change in the package of services offered. Adding a few components to the existing family planning programme will not transform it into a

'Reproductive Health Programme' that respects women's reproductive rights.

The following are some basic principles which should guide the formulation of reproductive health programmes:

Principles of Primary Health Care

- adopting a public health approach to reproductive health care, within the context of Primary Health Care. In other words, reproductive health needs are a subset of women's broader health needs, and need to be approached as such. There is no way one can improve a woman's reproductive health in isolation from her overall well-being.
- putting in place comprehensive and integrated programmes, rather than vertical interventions. For women, one reproductive health problem feeds into another. A vertical HIV/AIDS programme running parallel to an MCH/FP or 'reproductive health programme' is typical of a fragmented vertical approach.
- relying on holistic and integrated rather than on technical solutions.
- paying attention to basics: working towards the effective use of existing resources (e.g. equipping PHCs with personnel and resources necessary to make them functional), eliminating wastage and corruption.
- putting in place accountability mechanisms that make possible regular client feedback, and keeping the programme tuned to the needs of women and, indeed, men. More importantly, ensure that abuses will not go unquestioned.

Principles of Gender Equity

While the PHC approach is a basically sound premise to start from, proponents of the 'reproductive rights' agenda seek to redeem the 'gender blindness' which this approach was characterised by, having been the product of an era when gender inequalities were not explicitly recognised.

Towards this end, reproductive health programmes would

- Pursue approaches which promote women's empowerment, by enhancing their information base, and creating enabling conditions to make possible better self care and prevention and management of reproductive and other health problems.
- view women's reproductive health concerns within the context of their living and working conditions, and seek solutions aimed at primary prevention—i.e., social policies that would enhance their well-being.
- adopt a life-cycle approach to reproductive health needs, starting from before menarche and continuing post-menopause, instead of being narrowly focused on the pregnant woman and the family planning adopter.
- plan from the grassroots up, respect women's knowledge and definition of

their health needs and provide good quality services in a humane, gender-sensitive setting.

For example, the elimination of discrimination against the female child would be the starting point of any reproductive health agenda in the Indian context. One reason is that the health consequences of discrimination extend well into their reproductive years. A second, and more important reason is that discrimination and under-investment in girls is incompatible with an approach that seeks to empower women and vest in them the power and resources to make decisions concerning their reproductive and sexual lives.

The lynch-pin of the reproductive health programme would be the active participation of empowered women. To this end, efforts at the local level would be to involve women in spelling out their health needs; to equip them with information and skills that would help them initiate self-care at home, and seek appropriate help when needed; to become informed and discerning users of health services by insisting on adequate standards of care; and to seek solutions beyond the health care system when necessary.

It may be anticipated that such an approach would unleash demand for a wide range of services from the public health sector as well as other social sectors. The health sector would have to commit more resources to developing infrastructure and ensuring the regular functioning of health facilities, and also invest on improving both the range and the quality of services offered. Training of staff in new skills and providing quality care is a key element in making this possible. Another important area is gender sensitisation of staff in the health sector and in the other social sectors. Taking women's needs and concerns seriously would have to become the norm, and not the exception.

For the health sector, this implies nothing short of a radical departure from current strategies, and the mind set that has governed the MCH/FP programme for two decades. Fundamental changes would be needed in the designing and implementation of health sector interventions and programmes so that they help 'enable' and 'empower' women. These are not entirely new concepts, only 'engendered' versions of 'people's participation' upheld by the Primary Health Care approach.

Those concerned with women's reproductive health, and their well-being overall, cannot afford to lose sight of the larger issues that mitigate against these. Social policies that indirectly result in accentuation of gender inequities—the cut in expenditures on social welfare programmes would be an example—the social and economic consequences to women of structural adjustment programmes and economic liberalisation are not consistent with a commitment to promotion of reproductive health. We have to first ensure that we do not go a few steps backwards, even while we demand new policy initiatives addressing the pervasive gender inequities in our society.

There is a real danger that in the process of moving from rhetoric to action, 'reproductive health' gets reduced into a series of medical concerns with correspondingly medical solutions; a neatly packaged deal, consisting of 'screening

pregnant women for syphilis, prophylaxis for ophthalmia neonatorum and RTI screening before IUD insertions'. Another danger is that new emphasis on 'reproductive health' by international and bilateral donor agencies would result in a flooding-in of resources for 'reproductive health'—as they define it, while basic services and primary health care remain under-financed. Should this happen, it would be the very antithesis of what women around the globe have struggled for.

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World Bank's Reproductive and Child Health Approach: Old Wine in New Bottles

AMIT SEN GUPTA

After decades of devising various family planning targets, and strategies to meet such targets, the family planning (or welfare) programme in India has apparently decided to shed its target based approach. Interestingly, this *volte face* comes in the wake of recommendations to similar effect by a World Bank document of June 1995. This is probably not very surprising given the fact that major policy decisions in key sectors are taken today only after their "clearance" from foreign donor agencies. Thus, while the target oriented approach has invited criticisms from diverse quarters within the country for more than twenty years, the government has chosen to act only when called upon to do so by the World Bank.

I

Targets in the family planning programme in India have, for decades, been a major obsession. From the village *patwari* and school teacher, to almost all government functionaries working in rural areas, virtually no one was immune to the demands of meeting FP targets. Again, this is not surprising, considering the popular perception which links all social, political and economic ills of the country to its increasing population. Consequently, policy makers and planners in India have consistently treated the country's population "problem" as its favourite "whipping boy". From virtually the programme's inception in 1952, family planning targets have been translated to mean use of coercive measures to ensure contraceptive use. Promotions, postings and transfers of functionaries have hinged around fulfilment of targets related to contraceptive use. Down the years, the contraceptive methods to be propagated have changed - from Intra Uterine Devices (IUDs) till the 1960s, to vasectomy in the 1970s and finally to tubectomy and injectable contraceptives in the 1980s and 90s. What has remained constant is the single minded devotion to fixing targets and ensuring that these are met. The high noon of the target fetish of the programme was seen in the days of the Emergency between 1975 and 1977, and contributed in no small measure to the downfall of the then Congress Government. Yet, even this experience resulted in only cosmetic changes to the target oriented approach. Probably the only lasting effect was the one on nomenclature—the Family Planning Programme being renamed the Family Welfare Programme.

A dispassionate assessment of the programme in its four and half decades of

existence raises many interesting issues. Female sterilisation accounts for about three-fourths of contraceptive prevalence in India. Male methods account for only six per cent of current contraceptive use. Only five and a half per cent of couples use reversible modern contraceptive methods.

Total acceptors of contraception constitute just 43 per cent of couples in the child-bearing age group. Even this is likely to be a major over estimation, linked to over reporting—a bane of the target oriented approach—and to the fact that a large part of this figure is made up by tubectomies conducted on women towards the fag end of their reproductive life. Indirect evidence also indicates that the programme can hardly be held responsible for the few success stories in population planning in the country—Kerala and Tamil Nadu. Kerala's success in achieving results comparable to the developed world - vis-a-vis both demographic and health indicators—have been widely attributed to factors such as high minimum wages, land reforms, high literacy rates and access to universal health care. Much of Tamil Nadu's success in pegging down birth rates in recent years is being attributed to improved child survival due to the massive statewide feeding programme for undernourished children and improved communication facilities. Both experiences strengthen the maxim that "development is the best contraceptive".

II

Experiences within, as well as outside the country, show that a reduction in population growth rates follows overall socio-economic development. Except in conditions of war and famine, they seldom precede such development. Yet this has largely been ignored during our planning process, possibly as it prevents our planners from blaming the country's tardy development rates on the pressures posed by population increase. As a result family planning strategies have tended to be paternalistic, prescriptive and coercive. It is a strategy which starts from the belief that the poor breed prodigiously and it is the nation's duty to stem their unbridled fertility. Thus programmes are aimed at the poorest sections, and more specifically at women. Tubectomy rates in the country are fifty to hundred times higher than vasectomy rates, although the latter is a far simpler and safer procedure. Hormonal methods aimed at women find precedence over propagation of condoms, in spite of widespread reports that the former are associated with a large number of health hazards. In this whole process, the supposed beneficiary - the impoverished rural woman—has virtually no choice. She is at the receiving end of technologies which the state or society believe are necessary. Such programmes are inappropriate not only because they victimise women, but also because they do not work.

Such a strategy has undermined the effectiveness of the general health care infrastructure as well as the faith that women have in this infrastructure to address their real concerns. Most programmes have tended to view women as assembly line appendages required to produce babies. Thus a woman's health becomes important only when she is pregnant or lactating. But in India 65 per cent of deaths in women are due to infection related causes and only 2.5 per cent of deaths are due to causes related to childbirth. Even among women in the reproductive age group, only 12.5

per cent of deaths are due to causes associated with childbirth.

It is in this context that the new shift in population policies needs to be viewed. A target free approach is indeed a welcome change. Unfortunately, the World Bank's concern regarding the target free approach to family planning does not emanate from any of the concerns cited above. Rather, it is a reflection of the Bank's impatience with the alleged slow progress in third world nations towards controlling population growth. Population policies funded or dictated by the North, look for numbers as the ultimate bottom-line, not at esoteric statistics of empowerment and development. This agenda on population control follows from fears in the developed countries of North America and Europe that the resources of the planet will not be able to keep pace with the current rate of consumption. We are being made to believe that large population growth rates in the South is responsible for the global crisis in the environment. Yet the hidden agenda is related to the fact that the developed countries of the North are unable or unwilling to curb the consumption patterns in their countries. Each child born in North America consumes as much energy as three Japanese, six Mexicans, twelve Chinese, thirty three Indians, a hundred and forty seven Bangladeshis, two hundred and eighty one Tanzanians or four hundred and twenty two Ethiopians. Yet we are told that the poor nations of the Third World are the culprits who must listen to the voice of reason emanating from the corridors of power in Europe and America. The locus of coercion does not stop here. Third World nations, eager to implement population policies, pass on the burden of these programmes to the poorest sections of their population. This is again a part of the familiar argument that the poor 'breed' too fast and that is the root cause of their poverty. Finally, the ultimate victims (not beneficiaries) of population programmes are poor illiterate women. Thus a bulk of strategies for population control target women. This completes the *chain of coercion*—from the global North to the underdeveloped nations of the South, from the governments of these nations to the poorest communities, and ultimately women in these communities.

In the same breath that the new policy talks about the target free approach, it talks of a new Reproductive and Child Health (RCH) package, which shall replace earlier mechanisms. The essential coercive content of the family planning programme has, thus, been kept intact. As the name itself suggests, the concerns are with reproduction and not health. The gaze of the programme is still firmly fixed on women as targets.

Nomenclature notwithstanding, the new policy carries within it the basic core of earlier policies that made them unacceptable to large sections of women in this country. Women need access to family planning services because of their own health needs. But such access has to ensure not only that women have a choice, but that women are in a position to make decisions about their choices. In order for a policy to centre-stage women's concerns and needs, it should revolve around a package that addresses women's health in all its dimensions and not just their wombs. Women need access to contraceptive methods and information about their effects on their bodies. For this to happen, contraception must form part of a comprehensive health package. Any approach, unless willing to shed the paternalistic baggage of earlier policies, is likely to flounder.

It is in this background that the World Bank Report *India's Family Welfare Program: Toward a Reproductive and Child Health Approach* needs to be understood. As is the Bank's forte today, the document borrows heavily from terms in vogue among serious critics of India's family planning programme. Unfortunately this does not translate easily into sharing the same concerns. In order for the proposed approach to be seen as a break rather than as a continuation of older programmes, it must be demonstrated to be able to sever the chain of coercion outlined earlier as well as to locate itself within the real concerns of women.

The report starts by defining reproductive health in the following manner:

> Reproductive health can be defined as a state in which people have the ability to reproduce and regulate their fertility: women are able to go through pregnancy and childbirth safely; the outcome of pregnancy is successful in terms of maternal and infant survival and well being; and couples are able to have sexual relations free of the fear of pregnancy and of contracting disease.
>
> The principal goal of a reproductive health programme is to reduce unwanted fertility safely and to provide high-quality health services, thereby responding to the needs of individuals, as well as to concerns regarding population stabilization. A growing body of evidence, and the Cairo consensus, suggest that numerical, method-specific targets and monetary incentives for providers should be replaced by a broader system of performance goals and measures, focused on a range of reproductive health services.

The real intent of the "new" approach however becomes transparent when these goals are seen to be subservient to "broad social policy" and "demographic objectives". The document notes:

> The new consensus recognizes that an important goal of reproductive health programs should be to reduce unwanted fertility safely, thereby responding to the needs of individuals for high quality services, as well as to demographic objectives.
>
> While fertility reduction concerns can be addressed at the level of broad social policy, the design and management of reproductive health programs need to be directed primarily at the needs of actual and potential clients.

This is the crucial place where the Bank's prescriptions fundamentally differ from the concept of reproductive health as conceived by the feminist movement in the West. In the latter case reproductive health, as a genuine concern among a large body of women, stands on its own and is not seen as a means to an end. Here the logic is turned on its head and under the guise of addressing women's concerns the agenda of reproductive health is seen as a method of attaining objectives set by faceless financial institutions and governments. The program thus fails in its first test of being able to break the first link in the chain of coercion. The links in the chain of coercion, in fact, are sought to be strengthened and not weakened. The Report for example says:

> In May 1994, the Swaminathan Committee submitted to MOHFW a draft report with recommendations for a new national population policy. . . to promote an ***enabling political environment*** and community involvement in addressing family welfare issues (emphasis added).

This reference to an "enabling political environment" needs to be viewed in the context of the Swaminathan Committee's proposal to debar persons with more than two children from contesting elections to panchayats. Such amendments were in fact incorporated in the Panchayat Acts of Haryana and Rajasthan—curiously two states with the most adverse sex ratios. Indeed the World Bank document indicates that a totally new set of targets, incentives and disincentives would be required to replace the older set.

> FWP could... offer panchayats financial incentives to take reproductive and child health initiatives.
>
> Targets based on micro-level planning suiting the local specific needs may, however, continue to be fixed for monitoring of the program.
>
> An innovative package of incentives/disincentives would be formulated with emphasis on community based incentives and social security measures for individuals adopting small family norm. The ***community based incentives would be linked to various benefits being made available to the public under different socio-economic development plans of the government*** (emphasis added).
>
> A suitable package of disincentives will be developed for this section (government employees) of the society for adoption by the state governments as well. It will also be recommended to the employers in the organized sector.

Thus what the report is really talking about is ***not*** a winding up coercive mechanisms in the family planning programme but a ***widening*** of the net. The above allusions, if translated into policy, would mean entry and promotional avenues in all jobs in the organised sector (government or private) would be linked to family planning "goals". Furthermore, linking up incentives/disincentives with social security measures and socio-economic development plans are a clear threat that access to social security measures (to the limited extent that they exist today) will be made conditional upon adherence to prescribed family planning goals. Arguably this could cover access to loans under rural development programmes, rural employment programmes and even access to the Public Distribution System. It is inconceivable that the goals to which such access is subservient will in large measure, if not fully, not be determined centrally. So much for the rhetoric of a "client centred" approach. Linking social security access with demographic objectives in fact also serves a major agenda of the World Bank—limiting the state's expenditure in social infrastructure areas and food security.

The impression that has been sought to be created that the new approach, by doing away with local targets, would in one sweep free the programme of its essential tyrannical and oppressive core is entirely misplaced. For all the lip service paid to community and local self government involvement in the programme, the report

speaks of the perceived threats from panchayat structures in the following manner:

> . . .panchayats. . . may interfere with the technical integrity of the program, for example, by demanding curative care at the expense of preventive care, as happened after decentralization in China.

The "technical integrity" of the programme is thus seen as sacrosanct and not open to negotiation. The smoke-screen of a participative approach notwithstanding, the proposed approach is exposed for what it really stands for—a top down, patriarchal approach. This view is further strengthened if one examines the priorities set out in the report in terms of targeting and technologies.

> While sterilization would continue to play an important role in the population control efforts, it would be ensured that the profile of the acceptors would be of the right quality in terms of age and number of children already born.
>
> Many program managers fear that the removal of targets and incentives will undercut program performance. They also interpret calls for the elimination of sterilization targets/incentives as a call to shift program emphasis away from sterilization. That is not the message. Rather, the point is that sterilization should be available to meet the reproductive health needs of individual couples who wish to stop child-bearing. In all likelihood, the need for sterilization services will in fact expand rather than shrink, so that added effort will be needed to improve access and quality of those services.

Thus, female sterilization is to remain the linchpin of the programme and there is candid admission that a shift from targets in this area is merely tactical. In fact, elsewhere the report admits that this shift has largely been necessitated by the poor returns in terms of achievement of demographic goals rather than by concerns related to women's reproductive health. In keeping with its stated objective of providing more choices (through the cafeteria approach), the report's recommendations for new technologies to be adopted rely heavily on long acting hormonal contraceptive methods.

> The MOHFW recommended in the action plan that injectables (hormonal contraceptives) be introduced under the Program, initially under controlled conditions and gradually on a wider scale.... Given the need for safe, effective, and convenient reversible methods mentioned above, there seems every reason to phase this method into the program, with the necessary training, surveillance, and monitoring by the Indian Council of Medical Research and the medical colleges engaged in research and demonstration efforts regarding contraceptive methods.
>
> In order to give a wider choice of contraceptives to the acceptors, new contraceptives such as Norplant-6 and injectables shall be introduced under the program, initially under controlled conditions and gradually on a wider scale.

Such methods are, by their very nature, provider dependant. More so, in an environment where women are not literate and have very little access to information and health services. Introduction of these methods are thus an invitation to spread reproductive ill-health. The specific programmes mentioned in the report, possibly to justify the nomenclature of reproductive health, appear to have been picked for their so called cost-effectiveness. The report needs to be commended for the remarkable consistency in approach with the Bank's World Development Report 1993, *Investing in Health*. There too the primary concerns were cost effectiveness and targeting. The concern, clearly articulated in both documents, is to choose interventions which provide the best value for money and not necessarily where the burden of disease is the greatest.

> . . . treatment of RTIs and STIs is highly *cost-effective* (emphasis added).
>
> Antenatal services can detect and manage complications such as anaemia. Post-partum services include early detection and management of infections and haemorrhage and counselling in breast-feeding health, nutrition, and family planning. Provision of these services is *highly cost-effective.* (emphasis added)
>
> These include... prevention of gonococcal eye infection. . . the latter intervention is particularly *cost-effective*. . . . (emphasis added).
>
> However, while nutrition education can be provided to all pregnant and lactating women as part of routine pre and post-natal care, growth monitoring and supplementary feeding are time-consuming interventions that cannot be managed by the ANM.
>
> A more comprehensive package of reproductive health services should include more sophisticated diagnosis and treatment of RTIs and STIs, and cervical cancer screening and treatment, which has been shown to be *cost effective interventions* (emphasis added).

Thus in the Bank's schema, anaemia is a problem for women only when they are pregnant or lactating. On the other hand growth monitoring and supplementary feeding are not cost-effective. This needs to be viewed in the context that 80 per cent of women in India are anaemic and 63 per cent of children under five suffer from some degree of malnutrition—both figures are the highest in the world with the possible exception of Bangladesh. Anaemia in women is not just a consequence of reproductive ill-health—it is a function of diverse factors including discrimination of the girl child, undernutrition and social taboos. Child malnutrition is possibly the greatest tragedy of India with two-thirds of its population being maimed in its initial formative years and being consigned to a handicapped existence the rest of their lives. What in essence the Bank is proposing is a caricature of Reproductive and Child Health designed according to its peculiar logic.

The Child Health Programme was added to the Family Planning Programme in the post-Emergency days when a major refurbishing of the image of the programme

became a necessity for its very survival. The only real component of the Child Health Programme has been immunisation, to the almost total exclusion of other interventions (with the possible exception of the largely ineffective diarrhoeal disease control programme). Yet the report is congratulatory of the Child Health Programme:

> For the last decade, the FWP has gradually shifted its focus away from a predominant focus on family planning to a general effort to improve maternal and child health. . . . By 1992, ANMs were spending more time on immunization than on family planning.

Budget estimates show that the MCH component is only a minor component of the family planning programme and indeed has been declining:

Allocation for National Family Welfare Programme (in Rs. crore)

	1992-93	1993-94
Total	1099.91	1474.72
MCH	348.75	419.75
MCH as % oftotal	32%	28%

(Annual Report, MOHFW, 1993-94, Govt. of India).

Yet the document itself notes that MCH spending is far below World Bank recommendations:

> At about Rs.19.00 per capita per year... it (India) spends less on maternal and child health and family planning than the Rs.28.00 recommended for family planning alone by the World Bank's WDR, Investing in Health. The report considered spending on MCH and family planning to be among the most cost-effective health interventions, and recommended spending Rs.167 per capita for these services in low-income developing countries.

Thus by the Bank's own calculations MCH expenditure should be to the tune of 83 per cent of the total expenditure on family planning and MCH. Yet in India the situation is quite the reverse with MCH accounting for only 30 per cent of total expenditure on family welfare. By the Bank's own calculations India needs to spend 25 times more on MCH. Yet the estimates for increased investment required do not in any way reflect this, with a modest increase of 40-60 per cent of current levels being projected. If this is the level of evaluation of the existing MCH component of the family planning programme, there is very strong reason to doubt the seriousness of a commitment to the added component of Reproductive Health.

As in other areas the document also represents continuity in the present approach of pursuing family planning goals to the detriment of general health care. The report says:

> . . . spending on the disease control programs is increasing, and the workload of these programs threatens to cut into the time both ANMs and the MMPWs

> can spend on reproductive and child health work. A review of MMPWs' and ANMs' work loads should be carried out as a basis for policy decisions on the future strength of the MMPW cadre, ***and rationalization of the ANM's role in other programs.*** (emphasis added)

In other words, instead of strengthening existing health infrastructure, the report recommends drawing away more resources from it for family planning. Finally the document, again consistent with the Bank's old positions, makes a strong plea for greater role for the private sector. Unfortunately, unable to even conceive of even a limited "market" for Reproductive Health, the document's recommendations in this regard are full of internal contradictions and ill defined.

> The private sector presents the government with tremendous untapped potential for increasing the coverage of some reproductive and child health services.
>
> In the case of qualified, allopathic practitioners, experiments should be carried out with the contracting out of specific referral services at PHC and CHCs which are difficult to staff because of their remoteness.
>
> Surveys show that many PMPs are members of professional associations,. . . . Strengthened PMP associations may therefore be a potential channel for 'cascade' type training. . . .

Contracting out PHCs to the private sector can only allow profiteering. How this shall serve the so-called "client" base identified by the Bank is obscure. The PMPs the document talks of in rural areas are in essence unqualified quacks, and are engaged in a pursuit punishable by law. One wonders whether the Bank wishes to legitimise quackery as a systemic solution to India's health problems.

In conclusion, it may be said that the recommendations of the World Bank Report is in no way a departure from past practices of the family planning programme in India. It is part of the periodic attempts to refurbish the image of the programme and deflect legitimate criticisms. In this endeavour the report makes extensive use of terminology from feminist and radical groups. This is obviously a transparent attempt to co-opt sections which have genuinely opposed India's oppressive family planning programme. The report makes use of the concept of Reproductive Health, articulated by feminists groups in the U.S. and Europe. The concept flowed out of the concrete situation and genuine needs of a large number of women in those countries. It was never meant to be a concept that could be transplanted under totally different circumstances, nor was it designed to further the agenda of population control in demographic terms. Unfortunately this is precisely what the World Bank's Report tries to do.

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Fertility Control and Muslim Women in Hyderabad

SHEELA PRASAD AND SUMATI NAIR

While studies on the fertility of Third World women are numerous, very few have tried to understand what women themselves feel about fertility control. Indeed most studies implicitly seem to hold women responsible for their lack of fertility control without understanding the reality of women's lives and the compulsions they are subjected to. Of late there have been some initiatives to determine women's responses to fertility control and our study was conceived against this background. We felt it was time to hear from women, specially poor women, at the receiving end of the population control programmes what their experiences have been. In particular, some of the misconceptions regarding resistance to fertility control by women, specially Muslim women, were bothering us and we felt the women's voices needed to be heard. Some of the questions we began with were: is it true that women do not want fertility control? Is it a fact, as we are often led to believe, that women see the number of children that they have as a big problem? Do women have control over decisions on their fertility? If not, then why does the blame become theirs alone? Within the socio-economic constraints of their lives do women try to negotiate to control their fertility?

The study grew out of these concerns about women's fertility about which there were several presumptions but not much direct knowledge. Our research was confined to women in the state of Andhra Pradesh and covered both rural and urban women. In this paper we present some of our findings on fertility control and perceptions of Muslim women based on our study in Hyderabad, the capital city of Andhra Pradesh.

Hyderabad has a population of over 3.5 million which comprises about 60 per cent Hindus, 37 Muslims and 2.5 per cent Christians. The sizeable Muslim population is concentrated in the Old city and adjacent areas as historically this was the capital of the Nizam's dominion. The women in our sample were mainly from the Old city with a smaller number from the newer localities of the city. The women ranged from the poor of the slums of the Old city who were represented in larger numbers, to the lower middle class and an upwardly mobile lower middle class (based on remittances from the Gulf) also confined to the Old city and surrounding areas, and to the middle and upper classes from the newer colonies of the city. Most women we spoke to belonged to the 15 to 55 age group and a large number were living in joint families. The reason for singling out Muslim women as a separate category in this

paper is because the distortions in the accepted view are greatest with regard to fertility control among them. It is therefore important to document the perceptions of Muslim women about fertility control and understand the reality of their lives through their own experiences and voices.

Muslim Women and Fertility Control

Most women, rich or poor, know about contraceptive methods and it is only the older women above 55 years who said they did not know anything about them. But while women do now know about contraception, their knowledge is still extremely limited. Most women are only aware of sterilisation. Information about permanent and the different spacing methods, the side-effects and the health risks are not shared with women by the doctors and health staff. As a result, many women have many wrong notions and misgivings regarding these methods. Many asked us, "I heard women become fat and cannot do hard work after sterilisation, is it true?" In fact, family planning methods have been pushed so vigorously by the State over the years that today for a large majority fertility control is associated with the State and does not appear to be a matter of individual choice. This is particularly the case with poorer women and with regard to permanent contraceptive methods. Further, the wide-spread impression that Muslim populations are reluctant to use any fertility control method has made Muslim women extremely vulnerable to coercion and suspicion by the State health system. The backlash of such an attitude by the State is that a number of Muslim women avoid using government health facilities as they feel they are not treated well and are forced to accept sterilisation if they have more than three children. This view, we found, was shared by not only a number of Muslim women but also other poor women of the city. Many women told us—"we are treated very badly in the government hospitals."

With regard to contraceptive methods, we found that female sterilisation continues to be the prevalent method in the city. Spacing methods were used more by Muslim women than others due to some religious "restrictions" on sterilisation among some sections. Also, since Muslim women can remarry more easily they would like to have children in their next marriage and hence prefer not to get sterilised. One young woman explained, "tubectomy is not advisable for Muslim women because in case of death of her husband or a divorce, she can always get married to another man. Supposing the second husband wants a child from her it becomes difficult then." In spite of this so called "taboo", a large number of Muslim women do get sterilised in the city. In fact, we came across women who had got sterilised in the face of opposition from their husbands or in-laws. It seemed from their responses that while many women would prefer smaller families, it is the men who prefer having more children. Decisions on fertility control had sometimes to be taken by the women without discussion with the husband as the men did not give it much importance and felt it was the responsibility of the women. We often came across some of the dilemmas and problems faced by these women; the most frequent were as below:

"I wanted to get sterilised after my sixth child and my husband was also keen, but my father-in-law said No. Now I am again pregnant and my husband is angry with me."

"After my fourth delivery I went to another private hospital and not to Evita hospital, as I knew they do not do sterilisations in Evita, and I wanted to get sterilised."

"I got sterilised even though my husband was against it on religious grounds. He did not sign the papers but I was adamant and my other in-laws and my husband's elder brother supported me. As women have to bear and bring up children, we should decide on sterilisation and men should agree."

"I went to Suraj Bhan hospital to get sterilised without telling my husband, but my husband and mother-in-law came to know and shouted at me and the hospital doctor and took me away home."

There appears to be a class dimension in the use of contraceptive methods by the women. Poor Muslim women—like their counterparts in other religions—used no spacing methods, had three to four children and then got sterilised. For the poor of any community, fertility control means use of a permanent method as they cannot afford the expense and side-effects of temporary methods. One poor woman argued:"If anything happens to our health after using a spacing method, then what do we do? For us, there is no money for treatment". The family size of the poor Muslims shows a decline from the earlier generation and now averages around three children per family.

The lower middle class Muslim women tend to have larger families than the poor. In a few cases we found that the present generation of women in this group had more children than their earlier generation. The reason for this seems to be better economic conditions. Most of these families are sustained on remittances from the Gulf, each joint family having at least one member working there. With sudden prosperity the families can afford more children. There also appears to be a social dimension to this pattern which needs to be explored. Women with husbands in the Gulf get to meet them for only a few weeks once or twice a year. This separation perhaps builds a sense of insecurity and loneliness in the women. A few women confessed that they welcome pregnancy in such a situation, as having a child brings them closer to their husband and makes him happy. It may be mentioned that this is only an impression we got in our talks with a few women and may not necessarily be true of the majority. But it would be interesting to address this problem by talking to women in similar situations in Kerala and Hyderabad.

The upper-middle class and the rich among whom are the more educated Muslim women of Hyderabad practice spacing methods. Their family size has also reduced to an average of two children per family. Though there are some in this group who get sterilised, a larger number depend on spacing methods for fertility control. We came across one woman who had used a spacing method for five years to delay her first pregnancy. The most common spacing method used among the women is the IUD and there were a large number of women who had an IUD for three years and then got it replaced with another IUD. Condoms and the pill are not popular methods—the first because most men are reluctant to use it and the second because most women are now aware of its side effects. One woman confided to us, "I myself did not like it when my husband used the condom." Another complained, "With pills I had weight gain, weakness and a sense of not feeling fresh in the mornings."

That Muslim women practise and want fertility control cannot be questioned. Besides the modern methods of contraception, we came across use of natural methods like withdrawal and rhythm method, with the former method used more by Muslims. It also becomes apparent that abortion is increasingly seen as a contraceptive method though women do not admit it. Many women speak of having miscarriages and it is not clear to us if they are reluctant to admit having an abortion because of the social stigma it carries. We say this because most of the doctors we spoke to in the Old city and elsewhere reported a sharp rise in abortions by women, including unmarried girls. This is an option that is not available to the poor as they prefer to continue the pregnancy rather than bear the costs, both economic and physical, of an abortion. For women of the other classes, abortion is seen as a choice for control of fertility. One woman told us, "I read about the Marie Stopes abortion clinic in the newspaper and went all the way there to get an abortion done." In the control of fertility, information sharing and the experiences of close relatives plays a determining role. This is specially true in joint families where if one woman has a favourable experience with the use of a particular contraceptive method, other women in the family will use it. But on the other hand, if one woman has a bad experience, other women in the family will be reluctant to use any method. This appears to be the case with sterilisations that are followed by complications as quite a few women spoke of the fear of sterilisation as they knew of someone whose health had suffered post-sterilisation.

One impression we get from our study is that fertility control decisions rest not only with the woman, but to a large extent with the husband and mother-in-law. But we also came across situations where women have taken decisions to control their fertility despite likely family opposition by not confiding in their in-laws but seeking and getting support from their mothers and sisters. There are instances of such women going in for abortions, using the pill or even getting an IUD to avoid another pregnancy. One twenty year old woman, the mother of two small children and again pregnant who had come for an abortion had this to say. "I want an abortion. I told my mother-in-law and my husband that I had my periods but have actually missed them. I only told my sister about it and no one else knows in the family and I have come with my sister to get it done." Another woman admitted, "I had an abortion when my second child was only six months and I conceived due to failure of the withdrawal method. My husband and I decided to get an abortion done and we did not tell my in-laws as they would have objected. I have never felt guilty about getting the abortion done."

It becomes important to point out that the women would like to control their fertility and have fewer pregnancies, and in spite of pressures from their husband and family, that they do manage to negotiate with their fertility within their constraints. They may not protest and may appear to be passive sufferers but they do attempt to control their fertility in subtle ways that may not be discernible at once. The fear of repeated pregnancies is very real for many women. Some admitted how much they enjoyed sex after sterilisation or the use of an IUD. A few others practised abstinence for fear of getting pregnant again. For many women there is tremendous tension each month if their menses are delayed. One woman with very painful periods said,

"I get a lot of pain during the first two days of my menses. But in case my periods are delayed by a few days I start to get very tense and welcome my menses—the pain does not matter then." Yet another revealed, "Earlier, I used to feel uncomfortable and dirty during my menses. Now I willingly bear those feelings rather than be pregnant. In fact, I feel relieved when I get my menses."

In any understanding of fertility control, therefore, one needs to be sensitive to the socio-economic reality that women live in that determines and limits their choices for contraception. The social compulsions on a woman to prove her fertility immediately after marriage can be traumatic for her. Women fear that they are infertile if they do not conceive in the first few months of marriage. One woman admitted, "I was frightened when I did not conceive in the first three months of my marriage as I thought that my husband would leave me and marry another women." Perhaps in parenthesis we must mention here that we did not come across any case of polygamy in our sample and this is another popular misconception about Muslims that needs to be corrected.

Most woman would therefore use no contraceptives until they have proved their fertility. Motherhood seemed to be more important to the women than their health and for them their children were not numbers. A large number of women told us, "A woman is complete only if she has children"; "women are made by God to bear children"; "they have a duty to the husband to have children." One woman made an extremely telling comment, "women are fulfilled after bearing children. A woman can be complete without bearing any children but she will not be fulfilled."

Women do want fertility control. What they object to is coercion, the lack of information and the poor quality of services offered. Wherever the quality of contraceptive services is good, women have exercised their choice in the use of a method, whether it be a spacing or permanent method. Most women we spoke to did not perceive childbirth as having affected their health. However quite a few were of the view that the use of contraceptive methods, both temporary and permanent had adversely affected their health. In fact, women did not see the number of children they had as a problem at all as we generally led to believe. For them their major problems are the lack of money for food, school fees, medicines, the lack of proper facilities like drinking water, drainage and housing and the high cost of health care and the poor services in hospitals. They were also extremely worried about jobs for their children.

We would like to end this paper with the experience of fertility control of a young woman of 29 years in her own words. "After my first child was born I used the pill but found that I put on weight and felt weak but continued to use it. I forgot to take the pill once and conceived. As my child was only two months old I went in for an abortion with my husband's consent. I then asked my husband to use the condom and he tried it but did not like it. He suggested I use a copper-T and I got one inserted for two years even though it did not suit me too well as I had pain in the back and lower abdomen. I had my second child and now practise the withdrawal method which was suggested by a friend. I do not want any more children."

The Gordian Knot: Reproductive Health in the Context of India's Delayed Health and Fertility Transitions

MOHAN RAO

India's enormous diversities find reflection in the variations in the demographic profiles of distinct regions of the country. On the one hand, the demographic model state, Kerala has an infant mortality rate of 17 per thousand live births, a positive sex ratio, an expectation of life at birth above 70 years and below replacement level fertility—indices on par with the developed countries of the world. On the other hand, a number of states of North India have demographic indices of some of the least developed countries. Uttar Pradesh, which with 16.44 per cent of the population of the country in 1991 stood first among the states in terms of population size, had an infant mortality rate of 97—six times that of Kerala, the worst sex ratio in the world and an expectation of life at birth below 60 years and a total fertility rate of 5.3.

This paper briefly explores the demographic characteristics of some of the major states of India. By doing so, the purpose is to highlight the wide differentials among the states which makes any policy generalisation hazardous, even as it draws attention to the prevailing uneven state of health development. It is in this context that we must examine the current health policy approach of focusing on reproductive health care.

I

The Working Group on Population Policy[1], appointed by the Government of India, was the first policy document to explicitly recognise regional diversities in India's demographic scenario. It noted that "the large differentials in the socio-economic and demographic conditions and family planning performance in the country suggest that the strategies for the realisation of the demographic goals should be suitably modified and made relevant to each state". Towards this end, the *Report* suggested that the states be classified into three categories on the basis of eligible couples effectively protected. The groupings were as follows:

> Group A States (CPR <15 %): Bihar, Jammu & Kashmir, Rajasthan, and UP.
>
> Group B States (CPR 15-25%): Assam, Karnataka, Madhya Pradesh, Orissa, and West Bengal.

Group C States (CPR>25%): Andhra Pradesh, Himachal Pradesh, Kerala, Gujarat, Haryana, Maharashtra, Punjab and Tamilnadu.

The Working Group recommended a regional approach to health development with a differential mix of health, family planning and development inputs to enable the backward states to come on par with the others. The objective was that the Group C states achieve a Net Reproductive Rate (NRR) of 1 by 1991-92, Group B states by 1995-96 and the Group A states by 2001-2. The achievement of the goal of NRR 1 by 2000 AD among all the major states of India, it was recognised, was largely dependent on, among other factors, declines in infant and child mortality, improvements in health services in general and in maternal and child health services in particular and in nutritional standards. In the years since the publication of this *Report*, much water has flown under the bridges but what is extremely curious, if not poignant, is that the relative differentials between the states outlined above have been more or less maintained. Currently of course there is recognition that there are eight distinct demographic zones in the country.[2] These have been identified as follows:

1. Replacement fertility zone: Parts of Kerala and Tamilnadu.
2. Southern low-fertility zone: Parts of Kerala and Tamilnadu, Karnataka, parts of Maharashtra and Andhra Pradesh.
3. Moderate fertility zone: Gujarat, parts of Maharashtra and Andhra Pradesh, Orissa and parts of West Bengal.
4. South-eastern high-fertility zone: parts of Madhya Pradesh and West Bengal.
5. Northern high-fertility zone: UP, Bihar, parts of Madhya Pradesh and Rajasthan.
6. North-western high-fertility zone: parts of Rajasthan, Haryana, Delhi, parts of UP.
7. North-western moderate fertility zone: Punjab and Himachal Pradesh.
8. North-eastern zone: North eastern states, Assam and parts of West Bengal.

II

With this backdrop, we will now turn our attention to the data on some of the factors identified as critical to achieving health and demographic transitions. Table I presents data on the major states by population and the Crude Birth Rate by rural-urban residence.

The BIMARU states of Bihar, MP, Rajasthan and UP, which are all in the high fertility zone, together accounted for 39.67 per cent of the population of the country. All these states had a CBR well above the national average of 29.20 per thousand population. Indeed the CBR in the rural areas of these states were 33.1 in Bihar, 36.4 in Rajasthan, 36.8 in MP and 38 in UP. The TFR in these states was 5.1 in Bihar, 5.2 in Rajasthan, 5 in MP and 5.3 in UP compared to an all-India figure of 4.1. Assam and Haryana are two other states with a CBR above the national average. Kerala is of course startlingly different with a CBR of 17.7 per thousand followed by Tamilnadu with a CBR of 20.7. Other states fall in the range between

Table-I: Population of Major States and Crude Birth Rate by Rural-Urban Residence, 1991.

State	*Population*	*%*	*Crude Birth Rate Comb*	*Rural*	*Urban*
1. A.P.	66,508,008	7.86	24.5	25.1	22.3
2. Assam	22,414,322	2.65	30.8	31.5	21.4
3. Bihar	86,374,465	10.21	32.3	33.1	25.0
4. Gujarat	41,309,582	4.88	28.1	29.5	24.6
5. Haryana	16,463,648	1.94	32.0	33.8	25.3
6. H.P.	5,170,877	0.61	28.1	28.7	20.2
7. Karnataka	44,977,201	5.31	26.3	27.4	23.3
8. Kerala	29,098,518	3.44	17.7	17.6	18.3
9. M.P.	66,181,170	7.82	34.9	36.8	26.5
10. Maharashtra	68,937,187	9.33	25.3	27.4	21.5
11. Orissa	31,659,736	3.74	27.8	28.5	21.4
12. Punjab	20,281,969	2.40	27.1	28.3	24.2
13. Rajasthan	44,005,990	5.20	34.9	36.4	27.7
14. Tamilnadu	55,858,946	6.60	20.7	21.1	20.0
15. U.P.	139,112,287	16.44	36.3	38.0	28.9
16. West Bengal	68,077,965	8.04	24.8	28.0	16.4
ALL INDIA	846,302,688	100	29.2	30.9	23.1

Sources: Columns 3 & 4:Ministry of Home Affairs, Office of the Registrar General and Census Commissioner, *Census of India 1991*, N.Delhi, 1992.
Columns 5,6 & 7: Ministry of Home Affairs, Office of the Registrar General, *Sample Registration System*, 1992, N.Delhi, 1994.

these. What is even more striking about Kerala is the virtual absence of rural-urban differentials.

Table II presents the data on the infant mortality rates by sex and residence in the major states of the country.

Kerala is the only state in the country with an IMR below 20 and that, in both rural and urban areas. On the other hand, four states, Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan, account for more than 50 per cent of infant deaths in the country. The states of Madhya Pradesh, Orissa and Uttar Pradesh continued to have IMRs above 100 in rural areas; Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh had the highest IMRs for urban areas, above 75 per thousand live births.

Orissa presents something of a demographic conundrum, but the data above draw attention to not only the marked and persisting rural urban differentials but also the prevailing high rates of infant mortality in precisely those states of the country continuing to show high fertility rates.

Table III presents data on the child mortality rate (0-4 years) by sex and residence in the major states of the country.

It is well known that, like the IMR, the child mortality rate is a sensitive index

Table-II: Infant Mortality Rate by Sex and Residence in the Major States and All India, 1992

States	*Combined*			*Rural*			*Urban*		
	P	*M*	*F*	*P*	*M*	*F*	*P*	*M*	*F*
1. A.P.	71	73	68	78	80	75	42	43	40
2. Assam	82	86	78	83	90	79	50	40	61
3. Bihar	73	71	74	74	72	77	49	53	44
4. Gujarat	67	66	69	72	70	74	53	51	55
5. Haryana	75	73	78	79	78	80	56	47	67
6. H.P.	67	67	66	69	70	67	32	22	45
7. Karnataka	73	77	67	82	89	75	41	40	43
8. Kerala	17	21	12	17	22	12	13	14	12
9. M.P.	104	109	98	109	115	102	74	73	75
10. Maharashtra	59	61	57	67	68	67	40	45	34
11. Orissa	115	114	116	118	117	118	80	76	84
12. Punjab	56	54	60	61	56	68	41	46	34
13. Rajasthan	90	88	92	94	93	95	65	78	75
14. Tamilnadu	58	58	59	66	65	68	42	45	38
15. U.P.	98	92	105	102	94	110	78	79	77
16. W.Bengal	65	67	62	71	74	67	38	34	41
ALL INDIA	79	79	80	85	84	86	53	54	52

Source: SRS, 1992.

of socio-economic development. Indeed in the developed countries, this figure is five or below, a figure that in India has been attained by Kerala alone. The data above call attention to not just the rural urban differentials but the continuing high prevalence of child deaths all over the country; it is particularly marked in rural areas of Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Orissa. What is equally striking is that unlike the case with IMRs where gender differentials have ironed out, there are marked gender differentials in child mortality in these states, especially in the rural areas.

In short then, the data on IMR and CMR indicate that health transition in India is barely in the offing and has yet a long way to go. The prevailing high levels of infant and child mortality, then, are a reflection of the sorry state of social development in the country. Further, it is commonplace now to acknowledge that the largest chunk of these deaths are due to preventable causes not within the domain of currently available health technology.

Table IV offers data on some selected health service development indicators, namely, the performance in the Maternal and Child Health (MCH) component in the major states of the country.

We do not have data on the coverage of MCH services by rural and urban areas and would not be too far off the mark in assuming that the averages presented

Table-III: Child Mortality Rates (0-4 years) by Sex and Residence in the Major States and All India, 1992

States	*Combined*			*Rural*			*Urban*		
	P	*M*	*F*	*P*	*M*	*F*	*P*	*M*	*F*
1. A.P.	20.0	20.2	19.8	22.3	22.5	22.1	10.8	11.0	10.7
2. Assam	30.5	30.5	30.6	31.3	31.4	31.2	16.4	13.8	19.2
3. Bihar	26.8	24.2	29.6	27.6	24.7	30.8	17.7	18.5	16.8
4. Gujarat	23.7	22.8	24.7	27.5	26.4	28.6	14.7	14.1	15.3
5. Haryana	22.8	21.1	24.8	24.8	22.9	26.9	13.9	12.4	15.6
6. H.P.	17.6	17.6	17.5	18.1	18.2	18.0	8.5	7.7	9.5
7. Karnataka	21.7	22.6	20.7	24.7	25.8	23.5	12.2	12.5	11.8
8. Kerala	3.9	5.0	2.7	4.0	5.3	2.6	3.3	3.5	3.2
9. M.P.	38.5	36.8	40.3	42.1	40.4	43.8	21.6	20.0	23.3
10. Maharashtra	15.9	16.0	15.9	17.9	17.5	18.2	11.1	12.0	10.2
11. Orissa	33.4	31.7	35.2	34.4	33.0	35.9	22.0	17.8	26.8
12. Punjab	17.4	16.5	18.3	19.3	17.7	21.0	12.1	13.1	11.0
13. Rajasthan	33.6	31.2	36.3	35.9	33.5	38.6	21.3	19.1	23.8
14. Tamilnadu	15.3	15.0	15.7	16.9	16.0	17.8	11.8	12.7	10.9
15. U.P.	37.8	33.1	43.1	40.4	34.8	46.7	25.1	24.1	26.0
16. W.Bengal	18.4	18.4	18.4	20.5	20.6	20.4	9.8	9.4	10.2
ALL INDIA	26.5	24.9	28.2	29.1	27.2	31.1	15.6	15.4	15.2

Source: SRS 1992.

here conceal the gross under-provisioning of health service outreach activities in rural areas. What the data above all draw attention to, is the poor outreach with MCH services and the marked inter-state variations.

While the Universal Programme of Immunisation has received the strongest political backing and has hundred per cent targets fixed, the proportion of children receiving no immunisation at all is 34.4 per cent in Madhya Pradesh, 43.6 per cent in Assam, 43.3 per cent in Uttar Pradesh, 48.5 per cent in Rajasthan and 53.5 per cent in Bihar. On the other hand in Tamilnadu this proportion is 3.3 per cent and in Kerala, 11.4 per cent.

Similarly, the provision of ante-natal care is 97.3 per cent in Kerala, followed by 94.2 per cent in Tamilnadu. In contrast, it is 36.8 per cent in Bihar, 31.2 per cent in Rajasthan, 44.7 per cent in Uttar Pradesh and 52.1 per cent in Madhya Pradesh. Assam joins these states with an ante-natal care coverage of 49.3 per cent. The proportion of deliveries by health professionals ranges from a high of 89.7 per cent in Kerala, followed by 71.2 per cent in Tamilnadu to an abysmal 17.2 per cent in Uttar Pradesh, 17.9 per cent in Assam, 19 per cent in Bihar, 20.5 per cent in Orissa, 21.8 per cent in Rajasthan and 30 per cent in Madhya Pradesh. Again, while 90.1 per cent of all expectant women in Tamilnadu and 89.9 per cent in Kerala received immunisation coverage against tetanus, the proportion in Bihar was merely 30.7 per cent, in Madhya Pradesh 42.8 per cent, in Rajasthan 28.3 per cent and in Uttar

Table-IV: Selected Indicators of MCH Service Delivery by Major States and All India, 1992-93

States	*ANC*	*TT: 2 doses*	*% del med inst.*	*% del hlth prof.*	*compl. immun.*	*no immu*
1. A.P.	86.3	74.8	32.8	49.3	45	17.5
2. Assam	49.3	34.9	11.1	17.9	19.4	43.6
3. Bihar	36.8	30.7	12.1	19.0	10.7	53.5
4. Gujarat	75.7	62.7	35.6	42.5	49.8	18.9
5. Haryana	72.7	63.3	16.7	30.3	53.5	17.5
6. H.P.	76.0	47.4	16.0	25.6	62.9	8.7
7. Karnataka	83.5	69.8	37.5	50.9	52.2	15.2
8. Kerala	97.3	89.8	87.8	89.7	54.4	11.4
9. M.P.	52.1	42.8	15.9	30.0	29.2	34.4
10. Maharashtra	82.7	71.0	43.9	53.2	64.1	7.5
11. Orissa	61.6	53.8	14.1	20.5	36.1	28.0
12. Punjab	87.9	82.7	24.8	48.3	61.9	17.5
13. Rajasthan	31.2	28.3	11.6	21.8	21.1	48.5
14. Tamilnadu	94.2	90.1	63.4	71.2	64.9	3.3
15. U.P.	44.7	37.4	11.2	17.2	19.8	43.3
16. W.Bengal	75.3	70.4	31.5	33.0	34.2	22.4
ALL INDIA	62.3	53.8	25.5	34.2	35.4	30.0

Source: International Institute for Population Sciences, *National Family Health Survey 1992-93*, Bombay 1995.

Pradesh 37.4 per cent. Assam once again joins these states in very poor tetanus toxoid coverage amongst pregnant women with a figure of 34.9 per cent.

What the data make abundantly clear is the extraordinarily poor outreach of MCH services in these states, despite political commitment and the launching of special programmes such as the UIP and the GOBI-FFF. One proximate reason for the fact that these programmes have fallen short of their objectives, is the neglect of public health infrastructure in these states. This neglect was first engendered, and later compounded, by the vertical health programmes launched in the past which were themselves not quite successful in these states.

Some of these factors together find reflection in the data on the Maternal Mortality Rate presented in Table V.

The National Family Health Survey estimated that the average MMR for the two-year period preceding the survey in 1992-93 was 420 deaths per 100,000 live births. UNICEF's estimates provided above are slightly higher than the NFHS estimates at the all-India level. While the NFHS does not provide data at the state level, UNICEF's state level data is based on the observed global relationship between maternal mortality and infant mortality which is utilised to estimate state-level MMRs. This reveals that close to 125,000 women die in India each year from causes related to pregnancy and child birth. Kerala has the lowest estimated MMR of 87

Table-V: Maternal Mortality Rate by Major States and All India

States	*Maternal Deaths per 100,000 Births*
1. Andhra Pradesh	436
2. Assam	534
3. Bihar	470
4. Gujarat	389
5. Haryana	436
6. Himachal Pradesh	456
7. Karnataka	450
8. Kerala	87
9. Madhya Pradesh	711
10. Maharashtra	336
11. Orissa	738
12. Punjab	369
13. Rajasthan	550
14. Tamilnadu	376
15. Uttar Pradesh	624
16. West Bengal	389
ALL INDIA	453

Source: UNICEF, *The Progress of Indian States*, New Delhi, 1995.

deaths per 100,000 live births; in contrast states such as Madhya Pradesh, Orissa and Uttar Pradesh have one of the highest figures of MMR in the world. Reductions in the MMR are dependent not only on the provision of health infrastructure but on improvement in the health and nutritional status of women both before and during pregnancies.

Morbidity data are notoriously difficult to come by. The *NFHS* included data on selected morbidity over the two weeks preceding the date of survey and provides data on probable ARIs, fevers, diarrhoea and dysentery, the major causes of death in the 0-4 age group. The data are provided in Table VI.

There are, of course, problems with these data: of reliability, of comparability (since they are not point surveys) and validity. More fundamentally, looms the problem that morbidity data has a tendency to mis-state epidemiological problems, and therefore perhaps priorities, since they pertain to surviving populations, having elided the morbidities that took a toll.

Nonetheless, the data here draw attention to the extremely high morbidity load borne by the child population which cuts across the states. It is evident that the demographic model state Kerala, now closely followed by Tamilnadu, also has very high morbidity loads in the child population. What is equally crucial is that these morbidities are not amenable to control by technical interventions in the domain of health.

The *NFHS* also provides data on the prevalence of undernutrition in

children in the 0-4 year age group. Table VII provides the relevant data.

The caveats that apply to the morbidity data apply equally to the nutritional data also. Nevertheless, the data indicate that the nutritional status of the children of India is appalling. Slightly more than half her children are underweight, one in five of them severely so. Wasting affects more than one in six children while close to 60 per cent are stunted, 28.9 per cent severely so. The data alarmingly bring home the fact that India is home to the largest population of undernourished children in the world.

Given such high levels of under-nutrition, it is a trifle irrelevant to mark inter-state differentials. Nonetheless, it is evident that the problem of wasting is particularly evident in Bihar and Orissa and stunting in Bihar and U.P. with a host of other states lagging not far behind. Indeed, our model state Kerala has one in three children underweight and close to 10 per cent severely stunted.

III

The Working Group on Population Policy's recommendation that we achieve a NRR of 1 by 2000 AD was, in hindsight, obviously a mirage. It is currently envisaged that this goal will perhaps be achieved by the year 2027 provided large tracts of the country achieve improvements in health and development.

Table-VI: Prevalence of ARI, Fever and Diarrheas by Major States and All India, 1992-93

	State	*Cough & Dyspnoea*	*Fever*	*Any Diarrhoea*	*Bloody Diarrhoea*	*Diarrhoea in 24 hrs*
1	A.P.	4.9	16.5	11.7	1.2	6.0
2	Assam	11.3	24.6	6.3	1.3	2.4
3	Bihar	4.3	21.1	13.7	1.4	6.3
4	Gujarat	5.8	18.5	12.6	1.5	6.5
5	Haryana	5.4	18.6	12.0	0.9	5.9
6	H.P.	6.4	19.9	19.6	3.2	7.7
7	Karnataka	3.4	16.9	9.7	1.2	5.1
8	Kerala	9.7	35.4	9.2	1.5	3.4
9	M.P.	4.7	15.8	8.6	1.2	3.9
10	Maharashtra	5.9	21.7	9.7	1.0	5.1
11	Orissa	10.4	32.1	21.4	2.7	9.3
12	Punjab	3.1	19.9	11.0	1.1	4.4
13	Rajasthan	4.9	10.7	5.7	0.7	3.7
14	Tamilnadu	8.6	17.7	12.7	1.3	5.2
15	U.P.	7.2	19.1	8.9	1.5	4.6
16	W. Bengal	10.2	29.4	2.5	0.3	0.4
	ALL INDIA	6.5	20.2	10.0	1.3	4.8

Source: *NFHS*, 1995.

With the above scenario of birth rates, infant mortality rates, child mortality rates and a few of their determinants, it is clear that epidemiological transition—a change in patterns of health and disease and in the interaction between these patterns and their demographic, economic and social determinants[3]—has yet a long way to go in India. The only exception is Kerala which may perhaps offer us some insights.

Kerala's remarkable achievements in health, let us recall, came about without a reproductive health care approach. These improvements have been in precisely some of those areas which are now to be brought under the rubric of reproductive health care. But the instruments for these achievements in Kerala have been a complex of health, demographic and socio-economic factors which can perhaps be characterised as comprehensive primary health care. Thus in a state like Kerala the focus on morbidities, including reproductive ones, would perhaps not be misplaced. However it is nevertheless important to note that Kerala's achievements in health, education and social development has a foundation in a long history of public action towards social advancement which contributed indirectly to demographic change.

One of the main reasons for our failure in other parts of the country in the past, I would suggest, is that we have been side-tracked in our goal of universal comprehensive primary health care by other, perhaps more appealing in the short run, fast-track initiatives relying largely on health technology options. These initiatives have not met with the anticipated and desired outcomes as they did not pay adequate attention to constructing a base of either primary health care or the socio-economic determinants of health.

Table-VII: Nutritional Status Among Children Under Four Years by State and All India, 1992–93

1. A.P.	15.6	49.1	N.A.	N.A.	N.A.	N.A.
2. Assam	18.7	50.4	26.3	52.2	1.7	10.8
3. Bihar	31.1	62.6	39.5	60.9	4.1	21.8
4. Gujarat	17.6	50.1	25.3	48.2	3.7	18.8
5. Haryana	9.0	37.9	19.3	46.7	0.6	5.9
6. H.P.	12.9	47.0	N.A.	N.A.	N.A.	N.A.
7. Karnataka	19.4	54.3	22.7	47.6	2.6	17.4
8. Kerala	6.1	28.5	9.0	27.4	1.3	11.6
9. M.P.	22.3	57.4	N.A.	N.A.	N.A.	N.A.
10. Maharashtra	21.3	54.2	23.5	48.5	4.2	20.2
11. Orissa	22.7	53.3	25.2	48.2	3.6	21.3
12. Punjab	14.2	45.9	15.7	40.0	2.8	19.9
13. Rajasthan	19.2	41.6	26.6	43.1	5.2	19.5
14. Tamilnadu	13.3	48.2	N.A.	N.A.	N.A.	N.A.
15. U.P.	24.6	59.0	35.6	59.5	2.7	16.1
16. W. Bengal	18.4	56.8	N.A.	N.A.	N.A.	N.A.
ALL INDIA	20.6	53.4	28.9	52.0	3.2	17.5

Source: *NFHS*, 1995.

With vast regions of our country yet to undergo a health transition or epidemiological transition, fertility transition in the country has been delayed. Focusing on reproductive health now, in the absence of universal comprehensive primary health care—and its accoutrements—may yet again derail efforts towards Health For All while not being able to achieve the very laudable objectives of the approach of reproductive health itself.

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Rethinking AIDS in Women and the RHC Package: Some Epidemiological and Social Considerations

RITU PRIYA

Is AIDS in women only a problem of sexual transmission? Is it a reproductive health problem? Is placing AIDS within the reproductive health package the best way of dealing with the problem of AIDS in women? What are the possible benefits and negative consequences of such an approach? This paper attempts to examine the rationale of including AIDS within a Reproductive Health Programme. The possible consequences of such a strategy will be explored in terms of its effectiveness in dealing with AIDS in women and its impact on social perceptions.

We view the question from two stand points:

1. the conventional dominant public health perspective and
2. one which incorporates issues of the Indian experience with public health services and disease control programmes, the social and cultural context of the lives of majority of Indian women.

The dominant public health perspective[1] tells us that:

- AIDS is the most disastrous epidemic of current times that will wreak havoc across populations around the globe and therefore calls for the institution of emergency measures.
- Beginning with males HIV will increasingly infect women.
- The primary route of transmission to them is heterosexual activity.
- Safer sex practices, predominantly condom use, are the primary preventives.
- The risk of HIV infection is closely related to that of STDs.

This representation of the AIDS epidemic makes it logical for the advocates of the RH approach to include AIDS in the RH package which seeks to increase access of women to medical services related to sexual and reproductive health.[2]

A second look through more epidemiologically and socially tinted glasses, makes one rethink many of these assumptions. While affirming the validity of the statements made above, additional issues come into light which gives the problem a different hue. This multi-hued representation of the problem has significant practical implications for policy and programme formulation. In the fol-

lowing three sections we will discuss the missing shades in the dominant perspective, with India as the case study.

I The Epidemiological Context

The size of the AIDS epidemic in India is uncertain and controversial.[3] Yet the most probable scenario is being spelt out based on available data, the longer experience with HIV/AIDS in other countries and the historical experience of "new" diseases in human societies.[4]

The epidemic and endemic of AIDS: A long term view

AIDS is a disease that is here in India to stay, a disease likely to reach peak incidence

Table-1: Estimated and reported data on some causes of morbidity and mortality in India (1991/93)

Diseases	*Estimated*			*Reported*	
	Infected	*Cases*	*Deaths*	*Cases*	*Deaths*
Leprosy*	—	400,000	—	—	—
Malaria†	—	—	—	2,120,472	421
Filaria*	—	19,000,000	—	—	—
STDs †	—	—	—	1,363,838 (1989)	—
AIDS**	250,000 to 1,000,000 (by 1991)	12,500 to 50,000 (annual average by 2001)	12,500 to 50,000 (annual average by 2001)	237	-
Tuberculosis‡	40,000,000	12,000,000	400,000	1,040,772	9382
Acute respiratory infections (incl. pneumonia)†	—	—	—	10,529,381	6780
Diarrhoeal diseases (incl. cholera)†	—	—	—	9,351,033	7643
Infant mortality§	—	—	2,430,000	—	—
Cancer†	—	—	—	36,825	1442
Accidents †	—	—	—	—	169,066 (1989)

* *Annual Report. Ministry of Health and Family Welfare 1991-92.* Govt of India. pp. 28,32.
† *Health Information of India 1992.* Director General Health Services, Govt of India. pp.114,116-120,125,128,131,153.
‡ Computed from rates given in Suri A.K., *National Programme for Control of Tuberculosis. Programme Series.* New Delhi: National Institute of Health and Family Welfare, 1988.
§ Computed using a crude birth rate (CBR) of 30 per 1000 population and infant mortality rate of 90 per 1000 live births.
** Based on estimates for HIV sero-positivity in 1993 given by the National AIDS Control Organisation in *Country Scenario Update: December 1995*, NACO, Min. of H&F.W., GOI. Conversion rates from HIV positivity to AIDS cases used are from WHO.

of cases within the next few years and then stabilise at lower levels, finally persisting as a low grade endemic in the general population with some high endemicity pockets.[5] Even during its period of maximum incidence, the number of cases and the mortality will be the same as some other health problems and less than many others.

HIV/AIDS figures seen in isolation and in relation to other causes of morbidity and mortality depict two very different pictures. While studying the data in the table a few points must be kept in mind:

1. The reported cases are less than the actual figures because reporting is nearly always incomplete. Some diseases, for example, diarrhoeal disease and acute respiratory infections are under-reported more than others such as malaria.
2. The estimates are closer to reality than the reported figures.
3. The importance given to any public health problem should depend both on the levels of prevalence and on the severity of the condition in those affected.
4. The estimation of HIV positive persons done by the Global Programme on AIDS has been done through crude and simplistic methods which have been shown to be probably giving estimates higher than reality.[6]

The figures for HIV/AIDS in the fifth row show that the number of infected persons in 1993 was estimated by the WHO-GPA to be about 1.5 million. Within eight years 540,000 among the infected are expected to have manifest disease which amounts to an average of 67,500 a year. Adding another 32,500 for probable addition through the newly infected in the intervening years (1994-2000), we get a high annual average of 100,000 persons with AIDS. It can be estimated that about the same number will die of AIDS in these ten years as, once diagnosed, the mean survival period is only about six months. Against these estimates, the HIV-positive cases reported up to November 1995 were over 21,000 with 2097 AIDS cases.

Going down each column, we can see that the existing problems vastly outweigh the coming AIDS "menace". The number of diseased persons afflicted by chronic diseases such as leprosy, filariasis and tuberculosis far outnumber even the high estimates for AIDS. It may be argued that, even with smaller numbers, AIDS is more important because it is always fatal. What, however, does the data show us? Compared with the ***estimated*** number of AIDS deaths, the number of persons ***reported*** to be dying of acute respiratory infections (ARI) and diarrhoeal diseases is lower. However, if one estimates infant mortality alone, it is over 24 times greater. The top ten causes of infant mortality are tetanus, pneumonia, prematurity, dysentery, influenza, typhoid, diarrhoea, jaundice, bronchitis and diphtheria i.e.mainly ARI and water-borne diseases. These deaths are largely preventable by basic public health measures and medical services. In addition, a much larger number of persons than estimated to die due to AIDS are already reported to be dying of accidents. The number of cases of tuberculosis is 120 times more and deaths four times more than that due to AIDS.

A look at this broader picture shows us how bad the overall morbidity and mortality situation is in India. At the same time, it provides a far more realistic frame

work of AIDS problem to calm a panicky knee-jerk response. We therefore need to conceptualise AIDS in a long term perspective and plan for sustainable measures to deal with it. Even the short-term objective of lowering peak incidence must be addressed keeping this in view, not with the perspective of fire-fighting an impending disaster as the hysteria generated perhaps leads us.

Considering women and AIDS, we have two distinct epidemiological groups—the women in prostitution and women in the general population.[7] Among the latter, it is likely that there are many women with more than one sexual partner but in almost any class or social grouping in India, the majority are sexually faithful to their monogamous relationships. With little data on sexual behaviours in India, quantifying the numbers in the two groups viz. multi-partner and monogamous is based on "guesstimates".

Table-2: Estimates of HIV Positives for Three Alternative Scenarios

Risk Group	*Alternative Scenarios (size in millions)*		
	Alt1	*Alt2*	*Alt3*
High (CSWs, IVDUs)	0.50	1.00	1.00
Intermediate (STD clinic attenders, PBDs, client of CSWs)	1.00	5.00	25.00
Low (general population)	399.50	394.00	374.00
Number infected	0.44	0.50	0.61

Source: P. Singh - Projections on AIDS and HIV. *CARC CALLING* Vol.6 No. 3 Jul-Sept 92. 20-22.

The ICMR has used possible scenarios ranging from 0.5 to 1 million persons being in the high risk category of both sexes and 1 to 5 millions for those at intermediate risk. Others go still further and use 25 million (i.e. one in 16) as the figure for the latter. The proportion of population in the monogamous category (at low risk) remains way ahead in all three scenarios (Table 2.). The break up between the sexes has not been attempted. However given the magnitude of this group and the higher male to female transmission rate, women in the general population, those not engaging in any high-risk behaviours, are likely to be one of the largest sections to be infected.[8]

Routes of Infection

The routes of infection for the majority will be two, primarily sexual intercourse with their spouses who are infected and, secondly, through invasive medical intervention.

Patterns of Sexual Behavior Leading to Transmission

The dominant pattern of spread appears to be as follows: first infection introduced by international travellers, a peak of infection in IVDUs follows by a peak among

CSWs, followed by one in their clients and STD clinic attenders, and finally one in women in the general population. This suggests that the dominant pattern of HIV spread is from male clients to the CSWs, to other males who go for commercial sex, to their wives. This also suggests that many more men than women are "promiscuous". This pattern of sexual behaviour leading to transmission of HIV has been documented in many Third World countries.[9] Data from India is still limited to small studies with limited aspects examined in each. However they do indicate that the pattern is probably similar in India as well.[10] The extent of spread through multiple sexual relationships within the general population (i.e. without going to women in prostitution) remains unknown. This is an important gap in data because whatever little studies are available suggest that, for women, sexual relationships outside marriage are commonly within the family and the neighbourhood. The implication for AIDS control is clear viz. the need to target men for promotion of responsible sexual behavior.

Medical Transmission

While sexual transmission is, rightly, much written and spoken about, discussion on the iatrogenic transmission of HIV is largely restricted to blood and blood product transfusion. The high degree of injection use and of intra-venous drips with inadequate equipment relative to patient load in most government institutions, and the gross neglect of all basic safety procedures by health care deliverers at all levels and in all sectors of the medical system is well known. Yet no data has been collected related to this possible channel for HIV transmission. Most studies and data available come from the US and other settings in the industrialized world and pertain mostly to transmission from infected patients to health care deliverers or from infected health care deliverers to their patients. The only indication of the recognition of patient to patient transfer of infection is the propaganda/awareness campaign for use of disposable needles, syringes and other equipment. WHO documents and other technical literature also reiterates the need for practicing basic safety and antiseptic procedures in all medical interventions as a means of prevention of AIDS. However listing of this as a means of transmission is very muted or even absent.[11]

Since the possibility of medical transmission of HIV (other than through blood transfusion) has been underplayed, no data has been collected or analysed on this aspect. The Indian data on route of transmission is derived from the place at which the HIV positive person's blood sample was taken.

Data from NACO does not really tell us the source of infection, only the source from which the blood samples were obtained. For instance, in Table 3 the heterosexually promiscous group consists of samples from red-light areas and STD clinic attenders. It is then assumed that their source of infection must be heterosexual activity. That many among them could as well have been infected by the medical system is never considered or checked out. No one is asked for previous history of medical treatment.

Table 3 shows us that medical intervention clearly occurred in 10.4 per cent of those detected HIV-positive (groups 3, 4 and 6). Another 18.2 per cent avail of medical services as they have been detected upon their approaching the medical

Table-3: Break-up of Sero-positives

	Category	*Sero-Positive*	*Percentage*
1.	Heterosexually Promiscuous	17575	38.3
2.	Homosexuals	173	0.4
3.	Blood Donors	3773	8.2
4.	Dialysis Patients	231	0.5
5.	Antenatal Mothers	415	0.9
6.	Recipient of Blood SD/PDT SD/PDT	789	1.7
7.	Suspected ARC/AIDS	7948	17.3
8.	I/V Drug Users	2241	4.9
9.	Others	12721	27.8

Source: National Aids Control Organisation, Ministry of Health & Family Welfare, Government of India. ***Monthly Update on HIV Infection in India***, 31st July, 1996.

system for treatment (groups 5 and 7). Therefore it is likely that they have previous history of medical intervention as well. 27.8 per cent are categorised as "Others" and we do not know what that group constitutes. Is this data, then, masking the role of medical intervention in HIV transmission? Without specific data collection and studies no one can say, but with the poor state of medical care in our country, it is highly probable that this route contributes to much more than the 2.3 per cent (groups 4 and 6) acknowledged in official data. Table 4 shows data somewhat more reliable than that on HIV positive persons as it pertains to AIDS cases whose histories are likely to have been more closely checked. However here too the problems of a disproportionate predominance of samples from persons engaging in high-risk behaviour and of not taking medical histories (other than of transfusion) remains.

Table-4: AIDS Cases: Probable Source of Infection in India

	No.	Percentage
Heterosexual promiscous	2139	81.1
Blood transfusion	209	7.9
Blood product infusion	23	0.9
Homosexual contact	23	0.9
Spouse of AIDS pt./ sero-positive	34	1.3
Intravenous drug addicts:	127	4.8
Others	83	3.1
Total	2639	

Source: National AIDS Control Organisation, Ministry of Health & Family Welfare Government of India ***Monthly Update on HIV Infection in India***, 31st July, 1996.

II Planning and Programming for AIDS in Women

We need to plan measures with a combined long and short term perspective to minimise spread of HIV, detect infected persons and AIDS cases and provide support and medical care to AIDS cases. In the light of the epidemiological picture discussed above, the most important modes of prevention would be:

First line

i. Promoting monogamous relationships and
ii. Practice of routine anti-septic and safety precautions in all medical interventions at all levels.

Second line

i. Promotion of condom use.
ii. Use of disposable syringes.

Third line

i. STD diagnosis and treatment.
ii. HIV infection detection and care of AIDS cases.

We briefly examine some of the issues involved in thus hierarchising these means of prevention. These include considerations of epidemiology, of social and cultural context, and of organisation and implementation. The hierarchy indicates societal significance and role in prevention, not sequence of implementation which has to be concurrent.

Responsible Sexuality: Sexuality can be variously perceived—as a necessity for procreation, as an expression of caring, sharing and bonding between two individuals, as a means of deriving emotional and physical pleasure from transient relationships, as a means of sublimation and spiritual transcendence, as means of displaying power, punishing adversaries and so on. All strands, i.e. those giving primacy to one on the other view, exist in all societies at all times but the relative proportion of persons subscribing to different views change with changes in societal values and social conditions. Social control, self-restraint and the degree to which society values these, determine the dominant pattern of sexual behaviour in a society. India had Kamasutra and Khajuraho, socially accepted forms of prostitution (such as devadasis and courtesans), and polygamy and, on the other hand, a high value placed for the majority in all classes on faithful stable relationships within marriage. Of course there was greater space and tolerance for expression of male sexual desires outside a monogamous relationship than for women. As a norm, extra-marital and pre-marital relationships have been socially disapproved of even among those sections of society where such social mores are less rigid.

With India's shift from a predominantly agricultural low subsistence and low consumption economy and community based social structure to an industrially developing nation with urbanization, migration and the breakdown of rural economies and communities, there have been shifts in social values and world views. The degree

and nature of this impact has been varied across different sections. The weakening of earlier forms of social and community controls have allowed greater individual freedom, releasing the stifling controls on men and women. While most males by and large experience this autonomy, for women it is primarily the upper and middle classes who can claim it to some extent. Indications from different sources of data are that conditions of women of many sections may have relatively worsened.[13] High consumption life-styles have spread to a larger proportion, raised aspirations of others and increased the consumption gap between the top and bottom sections. Along with the increasing value placed on material consumption, there has also been an increase in perception of sexuality as a commodity to be consumed for pleasure. The gap between material aspirations and socio-economic status has led to distortions such as the spread of corruption, rise of the mafia, dowry deaths etc. Similarly there has been a rise in desires for sexual pleasures and "consumption" but these are not possible for the majority to fulfill through socially legitimate relationships given the nature of gender relationships, the pattern of family relationship and the level of living conditions including housing. This, together with the loosening of community ties with no concomitant replacement by any other form of social control, with a decline in values of self-restraint and in shared norms for respecting other's rights has led to a rise in sexual assaults on women and even the girl child. These gross perversions of sexuality of men indicate the less visible shifts in social behaviour in our society. Increasing prostitution reveals the increasing demand for commercial sex.[14] Pre-and extra-marital relationships are thus likely to be on the rise, and some surveys do indicate high levels in different sections. All these changes are most conducive to the spread of AIDS in women.

However when we compare the scene with information available on sexual norms and behaviour in other societies, we still seem to be "conservative" and the sexual restraint maintained is of a higher order. Whether it be the industrialized West, the African situation or closer home, Thailand, the social sanction against transient multi-partner relationships is much more. The impact of this is evident in the levels of HIV infection in these respective areas.

The east and central African countries, the USA and Thailand all have much higher HIV infection rates than estimated for India. Whatever little data is available indicates epidemiologically significant difference in "sexual culture": in the proportion of persons engaging in sexual relationships outside marriage and in the degree of partner change among them. For instance, the average age at sexual initiation was found to be 15 years for girls in Uganda, 16 years combined for both sexes in the USA and 17-19 years for boys with 20 years for girls in India. 50 per cent of male high school students in Zaire and Zimbabwe and over 70 per cent of male university students in the US sample were found to be sexually active, while only 20-25 per cent of male university students were found to be so by different studies in India. Among female adolescents, only three per cent were sexually active among high school pupils in Zimbabwe, 56 per cent were active by the age of 18 years in the US and less than ten per cent in diverse groups within India. Urban Ugandan women aged 20-30 years were found to have had an average of two partners over the past five years, while 44 per cent of univer-

sity students in the US had two or more in the preceding one year. Socio-cultural norms have undergone a "sexual revolution" in the US over the post-War decades with a highly individualised, hedonistic current sweeping across that society. In the east-central African nations, drastic change from tribal society to ecologically and economically devastated conditions along with "modernization" has meant superimposition upon highly patriarchal, often polygynous social norms, the impact of male migration to urban and mining areas, rise in prostitution and in various forms of short-lived relationships. The study of urban Ugandan women found 37.5 per cent legally married, 37.5 per cent living in consensual union, 15.6 per cent in visiting union. 31 per cent were living in a polygynous situation.[15] Though HIV reached Thailand and India about the same time, the-former, with its sex tourism industry, its earlier opening up to the world economy and the subsequent destitution of large sections of the population [16], the social norm of young men going to women in prostitution and its place within the golden triangle of drug abuse has a much higher sero-positivity rate.[17]

With our economy undergoing structural adjustment and globalising, we too are under increasing pressure of socio-cultural change in conformity with the global thrust of the pleasure seeking, high consumption, individualistic world-view. Commercial advertising is entirely devoted to this end. Analysis of the mass communication approach of the global and national AIDS programme in India has shown how, unfortunately, it too is contributing to the neo-colonial cultural onslaught and to reinforcing existing negative stereotypes.[18] While we need to open up social avenues of self-actualisation and creativity of both men and women, we need to retain the positive within our context and strengthen it. This cannot be done through coercion or preaching but by communicating the personal gains of self-restraint as a value. For instance, a monogamous relationship can be made attractive by highlighting its emotional and romantic content and its obligations. While traditionally the social pressure for meeting obligations has been on the woman, socialisation now should be targetted at responsible male sexuality so that it becomes a truly mutual monogamy. Also, care must be taken to ensure a non-stigmatisation of other, less common, expressions of sexuality. This is only marginally an area for the health care delivery system and calls for much wider socio-cultural and political interventions.

Till now most IEC material related to AIDS has done the opposite i.e. in the effort to be "non-moralising" and "non-judgemental" they have promoted ideas of "free sex" and the commodification of sex. While the women's empowerment agenda highlights freedom from social controls for women, demanding greater sexual and reproductive freedom and rights for them, in the case of the majority of Indian women this has to be viewed as freedom from sexual harassment, assault and coercion and the right to participation in sexual decision-making. This requires not only the empowerment of women in other spheres of life but also the redefining of sexual stereotypes and images for men. Reworking norms for gender relationships and involving men in the process is thus the challenge. How to strenghthen the dominant value for monogamy with inbuilt space within society for diversions from the norm is the additional challenge.

Promotion of condom use is a secondary line of prevention against sexual transmission because (a) it is actually necessary only for the minority who do engage in multiple sexual relationships; (b) its limitation is that it cannot be enforced by women; (c) that couples wanting conception cannot use it; and (d) uncertain availability, cost, quality and variable skill of users detract from its protective efficacy.[20]

A Responsible Medical Care System

Primary prevention against medical spread of HIV simply requires routine safety precautions to be adhered to. Information about the fragility of the virus needs to be emphasised and the anti-infective measures needed to destroy the virus needs to be constantly reiterated. That it is primarily the routine, basic sterilization procedures which are necessary is to be driven home.[21] AIDS control activity must improve the performance of our medical and nursing personal in this regard.

To implement this effectively requires a major overhauling of our medical care delivery system but this is long over due. What we need to do is to re-educate our medical and nursing personnel and, at the same time, to actively work on developing appropriate and convenient ways of anti-septic procedures which can be adopted easily under conditions of over-work and resource contraints. A blend of time and work studies, bio-medical engineering, operations research etc. would be needed. Such research, followed by ensuring conditions for its application in our medical institutions, should be the primary focus of the AIDS control programme. It will help not only in AIDS control but in improving health services all around. If practiced within the government institutions it will provide a pressure on other sectors also.

At the same time we must guard against the danger of increasing procedures and expenditures in the name of protecting against spread of HIV. It was estimated, for example, that in the US, dentists alone have increased spending on infection-control measures by about 525 million dollars a year based on "media hype and the exaggeration of experts with little objective examination".[22] Additionally, we need to cut out all unnecessary medical interventions. Blood economy is being promoted but we need to increase much greater awareness against unnecessary injections and I-V drips, the more commonly misused invasive interventions.

Use of disposable medical equipment is, similarly, a second line measure not universally applicable but to be applied only in certain situations. It only adds to unnecessary and heavy expenditure. The case of a hospital in Bombay stopping reuse of equipment in heart-valve surgery has unnecessarily deprived many poor young men and women of this life-saving surgery as the cost reportedly went up from a few thousands to over seventy thousand rupees. These are totally unnecessary precautions since simple autoclave would kill any possible HIV contamination. Further, methods suitable in other settings may not be the best for us in the Indian context. For instance disposable syringes, needles and i-v sets are likely to be picked up from the hospital waste and recycled as pre-sterilised disposable material again. The surest way to ensure safety is to boil a syringe and needle just before use

for 20 minutes. This is possible with the least cost even in the most unsophisticated settings.

Linking STD and HIV/AIDS

STD diagnosis and treatment has been labelled the third line of prevention for a number of reasons. The claims of the benefits of this programmatic linkage are however doubtful for several reasons. The high association between STDs and HIV infection is well documented. The co-existence of the two is, however, more a reflection of the common route of spread than STDs increasing susceptibility to HIV. Multivariate analysis by different scientists provide contradictory findings, some favouring the hypotheses of increased susceptibility while others do not find evidence to do so.[23] Even if RTIs and STDs do increase susceptibility to AIDS, will this make a significant difference to women with infected spouses with whom they have a sustained sexual relationships? Even in women without an ulcerative lesion of the reproductive tract i.e. those with lower susceptibility, repeated exposures are likely to lead to infection unless they have rare innate resistance.

STD clinics are the most obvious sources for detection of HIV infection in the general population. However, not many STD cases go there with only an estimated 10 per cent currently reaching them.[24] The proportion of women is even lower. This is not only because women in general access the medical services much less than men but also because STDs produce obvious symptoms in very few women. Access of women to good general health services, including gynaecological services, is the only means of detecting STDs in women. Treating STDs through special clinics can deal with infected males alone; women will only benefit indirectly. Further, the symptoms of AIDS are non-specific and may relate to any system. Thus detection of cases in women can happen only when women come to the general health services for their non-specific symptoms, the health care providers are aware of AIDS signs and symptoms and they have back-up facilities for referring suspected cases for testing.

The linking of AIDS and STDs can, however, be of benefit to women if it promotes the idea of faithful and responsible monogamous relationships among men. This is a complicated issue which lies outside the activity of the medical system per se and depends upon communication and education activities in addition to wider socio-cultural processes.

Addressing the health care needs of women in prostitution would be of benefit both to these women and to the general population. Greater attention to the RH of CSWs as part of basic medical care for all their health problems appears much more meaningful for these women for whom RH problems arise not only as life cycle related ones but also as occupational hazards. However the RH programme is focussed on women to the near exclusion of men and the complete absence of the women in prostitution.

AIDS and General Health Services

The general health services have a major role to play in detecting and treating AIDS cases for several reasons, some of which we have already touched upon. Diagnosis

of both STDs and AIDS in women requires effective general health services. However over-diagnosing of AIDS/HIV is a danger which must be consciously guarded against as it will cause unnecessary suffering. Some under-diagnosis may not be too much of a loss to the person wrongly diagnosed "not AIDS" because no specific treatment is available anyway. Utilisation of voluntary, anonymous, testing facilities would be the most efficient means of limiting medical over-diagnosis.

Effective medical services which evoke confidence and trust are essential prerequisites for this. However, poor quality of medical care and the lack of popular confidence and trust in the medical system is well-known. How to build up quality care and credibility are therefore essential for STD and AIDS action and of course for all other medical problems as well.

For building confidence in HIV-testing and AIDS care itself, informed consent for testing, counselling and non-isolationist services have been advocated. However, the ICMR, in its wisdom, has decided that no informed consent is necessary for testing in India. Counselling is of course a far cry in a system where even simple human communication between a doctor and a patient is a rarity. This issue is, however, not being adequately addressed.[25]

No health service can gain credibility among its "clients" if it provides RH care but does not treat other common conditions such as fevers and diarrhoeas. We have seen how the role of STDs and RTIs in increasing susceptibility to HIV infection remains unproven. Equally valid, but equally unproven, is the role of a high load of infectious disease and malnutrition in increasing susceptibility. However studies showing the first association have been highlighted while the second remains poorly known and studied. These could be important lacunae in our knowledge of links between general health and AIDS susceptibility and viewing it as a RH problem will deny the possibility of these links with possibly deleterious outcomes for the RH programme itself.

For the care of the detected AIDS cases, we will need to have family and community care supported by the health services. This will mean a further sensitization of the health care providers to supportive interaction with the patient, family and community. The health care providers should be providing the lead in building a non-stigmatising attitude towards the person suffering from AIDS. At present the scenario is the opposite, with many reports of doctors refusing to treat HIV positive persons.[26] This must be a major area of action but is barely mentioned.

Further, they need to be sensitive to the greater negative social impact on HIV positive or AIDS cases among women than among men. Both the stronger social reaction against women who break social norms, specially relating to sexual behaviour and women's weaker socio-economic status makes them more vulnerable to destitution once labelled HIV positive or an AIDS case. Ensuring support to such women is essential not only from a humanistic point of view but also from the public health perspective of minimising spread of infection as such social stigma and ostracisation makes AIDS prevention activity more difficult.

A greater awareness of medical intervention as a possible source for contract-

ing the infection is likely to decrease the stigma and ostracisation. It will make AIDS less of a "moral" issue while allowing for the benefit of doubt to the HIV positive person who is otherwise certain to be labelled "promiscuous" and socially persecuted.

Thus, clearly, a much larger canvas is needed to effectively address the social and medical aspects of dealing with AIDS than the single programme approach currently practiced.

III AIDS in the Reproductive Health Package

The primary rationale for including AIDS in the RH package appears to be technically and conceptually sound viz. that the predominant route of transmission, measures for prevention and channel for detection of infected persons are all related to sexual and reproductive events and ill-health in women and therefore putting the services together makes good public health sense. However, the foregoing discussion has shown that for AIDS in women the specific preventive action has to be directed at men. This is for two reasons as has been pointed out: one, neither do the symptoms suffered by the women with AIDS present to them as reproductive tract problems nor are the majority of them afflicted due to their own behaviour related to the reproductive system. Two, condom promotion is a secondary yet important line of action. But incorporating it within a women-centered programme puts the onus of use on them which is both unfair and futile in the existing power equation between the sexes.

The second focus of action against AIDS in women has to be the medical service system for ensuring the practice of anti-infective procedures, for sensitizing it to women's special circumstances, for ensuring women's access to the services catering to both gynaecological and other symptoms, for developing credibility and trust and for developing its capacity to link up with the community for care of AIDS cases. Women must get accurate information but they must also have the economic, social and psychological resources to act upon that information.

An RH Programme aimed at accessing reproductive services for women thus cannot provide any concrete benefits to women directly in relation to AIDS. On the other hand, linking AIDs to RH will negatively influence social perceptions of the disease which are crucial for AIDS control.

Influence on Social Perceptions

Incorporating AIDS into a programme focussing on women and reproductive health will reinforce the false perception that women primarily spread the disease to men. The promotion of this patriarchically constructed view will only disempower women further.[27] Placing AIDS within RH denies the wider linkage of effective basic health service with AIDS. It allows the iatrogenic spread of HIV to be underplayed thus facilitating the continuing neglect of measures to check it. The only source of infection popularly highlighted being "sexual promiscuity" will add to the persecution of

infected women further. No space is left for the benefit of doubt which the highlighting of iatrogenic spread will provide. Including AIDS within RH may contribute to gender sensitisation of the AIDS programme, but this will not automatically mean gender sensitisation of the whole health services. The health care workers will remain insensitive to women's issues in relation to tuberculosis, malaria and other spheres of their work because they see each programme as a discrete entity. All these, and not just the AIDS programme, need to be sensitive to women's special problems but they cannot of course be part of the RH package.

Summing up

Thus including AIDS into the RH package is perfectly logical for those committed to making the RH programme as comprehensive as possible. Conceptually, technically, in terms of the dominant mode of spread, prevention and diagnosis, AIDS fits into R.H. However, when this conceptualisation includes wider epidemiological and social considerations it does not appear so logical. It puts the onus of the spread and prevention on women without providing them any concrete support. It allows the current dominant perspective in AIDS control which ignores the links of AIDS with basic health problems and basic health services to continue unchallenged. It also ignores the whole complex realm of sexuality while attempting to promote condom use. Without acknowledging that sexual behaviour is socially constructed, without using the existing socio-cultural context as a resource and building upon it, an attempt is being made at massive cultural change through a simple technological fix. On the other hand, while advocating the wearing of a plastic sheath universally and each time the most primal human act is performed, the scientific medical interventions by professionals within the health system are not targetted for behavioural and cultural change. Thus it reinforces the existing anti-women power equations, whether between men and women or between women and the experts and professionals.

If the RH programme incorporates the sexual and RH of men, if it provides health services for women in prostitution, if it focusses on gender sensitization of the general health services, if it improves safety procedures within the health services and if it initiates a change in norms within gender relationship then perhaps incorporating AIDS in the RH package will be of value to women. But then will it still be the current RH approach?

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12. "The risk of HIV transmission in health care settings, i.e. from doctors to patients or vice versa from patient to patient is very low - only 0.3 per cent when, for example, a health care worker may get a needle stick injury thus exposing himself/herself to HIV": WHO (1992): *AIDS in South East Asia: No Time for Complacency*, pp. 12.
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NGOs in the Time of Globalisation

VIMALA RAMACHANDRAN

In the last two years both voluntary organisations working in the area of health and women's groups have attempted to come to grips with the concept of 'Reproductive Health'. This new-found enthusiasm has been criticised by a wide range of social activist groups who see it as yet another donor driven agenda. Discussions on the appropriateness of a vertical programme that deflects attention from primary health has renewed the debate on whether voluntary organisations are really voluntary and to what extent non-government organisations (NGOs) are autonomous in setting their own priorities and agenda in the area of health and family planning—especially in an era of globalisation and liberalisation.

For almost five decades 'Health For All' has been an elusive goal. Various permutations and combinations were tried by the government; yet—like primary education—delivering quality primary health care facilities to the people has remained at the level of slogans and rhetoric. Technically almost 85 per cent of our population is covered by a Primary Health Centre (PHC); doctors are posted in rural areas; medicines are supplied to all PHCs and referral services are available. On paper, the system is supposed to work.

But this is where the comparison with the education sector ends. Unlike primary education, the health delivery system in India has been dominated by demographic goals—almost overshadowing the primary agenda of the government. For 40 years our system was driven by method-specific sterilisation targets—unlike almost all the other social sectors—and the government machinery spared no effort to achieve them. On this one point the entire health delivery system worked—from the Auxiliary Nurse Midwife (ANM) to the Medical Officer—every one had to achieve targets set by the state.

The political-administrative will to achieve targets was evident down the line: chief secretaries had family planning (FP) targets on their monthly check-list, district magistrates made it a point to ensure achievement and promotions and other avenues of professional advancement were linked to FP targets. It was apparent to all that given political and administrative will, the government system performs.

This inherent contradiction within the health care system has left a strong impact on the voluntary sector. Voluntary organisations were split across the middle—between those who supported and participated in the government's FP programme and those who were open critics of the coercive system. Donors operating in India were also categorised according to their role in encouraging or promoting India's demographic goals, and those who kept a safe distance from it and saw it as a

violation of basic human rights. Voluntary organisations therefore were not just split according to their public position on FP but also on their relationship with donors who were publicly identified with demographic goals. Politics among the NGOs and networking between groups was thus greatly influenced by India's FP programme and intention, encouragement and support for it. This prompted a commentator to observe that "The legitimacy of the NGO is no longer based upon values and voluntarism but on its contract to a legitimate agency".[1]

Since the mid-70s women's organisations, social activist groups, radical political parties and community based organisations have raised their voice against the contradictory positions taken by government on population and family planning. At one level, at the Bucharest conference, India touted the slogan—'development is the best contraceptive'. At another level, back home, the government intensified its efforts to control population growth. The darkest period was during the Emergency (1975-77) when excesses committed in the programme brought the government down. After a brief lull, the renamed (not revamped) Family Planning Programme came back with a bang—with one significant difference. Women were now the target since male sterilisation had proved politically volatile. Tubectomy camps and laparascopic techniques coupled with incentives and disincentives became the government's one point programme and the entire might of the administration was geared towards achieving targets. This approach continued through the 80s.

The first glimmer of doubt was expressed by the Planning Commission in its approach paper to the Eighth Plan. It stated: 'in spite of massive efforts in the form of budgetary support and infrastructure development, the performance of the family welfare programme has not been commensurate with inputs. Right from the beginning the achievement of the set of goals has been unsatisfactory, resulting in the resetting of targets. . . While the Seventh Plan targets of achieving CPR of 42 per cent was achieved, this was not matched by commensurate decline in the birth rate, possibly because of improper selection of cases. . . Containment of population is not merely a function of couple protection or contraception but is directly correlated with female literacy, age of marriage of girls, status of women in the community, IMR, quality and outreach of health and family planning services and other socio-economic parameters. . . The Family Welfare Programme has essentially remained a uni-sector programme of the Ministry of Health and Family Welfare. . . (it) has also suffered on account of centralised planning and target setting from the top. . . Monitoring mechanism under the programme has been reduced to a routine target reporting exercise incapable of identifying roadblocks and applying timely correctives'.

Community based groups, social activists and women's organisations intensified their public protest against the family welfare programme. Almost all made it a point to distance themselves from it. Activists in the women's movement and women's organisations critiqued the programme from the outside. By the early '90s this sharpened—so much so that the Ministry of Health and Family Welfare started looking upon women's groups as adversaries. Women's groups agitated against human rights violations in the form of family planning, harmful technologies and the abysmal quality of health care services. Women's development programmes within the government, like the WDP Rajasthan and Mahila Samakhya, made conscious efforts to

not only distance themselves from family planning but also actively campaigned for the woman's right to make her own decisions and her right to dignity.

Where did all this lead her to? Right through the 80s and in the first half of the'90s, there was little dialogue between the two constituencies of family planning *wallahs* and women's groups. As a result voluntary organisations, demographers, part of the population lobby and family planning associations were identified with the establishment. Government propaganda—lessons in school textbooks, media stories about the population bomb, international advocacy for reduction in population growth—created a situation whereby the two extreme positions received public attention: one which stated that population must be controlled at any cost as it is the root cause of poverty and the other which argued that high population growth rate is a symptom of poverty, ill-health and lack of social security. Middle-of-the-roaders who argued for a more nuanced and balanced view of the population-poverty linkages were either silent or found their advocacy ineffective.

By the middle of the 90s an appreciable softening among the population hardliners became evident. Many decades of pumping money into contraceptives and sterilisation had not yielded desired results. Evidence from several poor countries demonstrated that human development indicators are not necessarily correlated with economic prosperity. Quality primary health care, maternal and child survival programmes, good sanitation and primary education can turn the tide. When infant mortality decreases and people feel assured about the survival of their children, family size begins to decline. Globally, the efforts to develop human development indicators and the ranking of countries according to quality of life, forced demographers and population control *wallahs* to rethink. The environment question and the carrying capacity of the planet also pointed towards consumption patterns among the rich and poor across the world as also within countries. All these effectively diffused the population bomb.

In India, some women's organisations, social activists, researchers and officials recognised the historical opportunity. By 1993 it was so evident that a significant section of policy-makers and administrators within government articulated the need to overhaul the family welfare programme. Target fatigue had set in. A draft note for discussion among Secretaries to Government of India made the round in the early '90s. Some senior civil servants reached out to talk to women activists. Preparatory activities for the Cairo conference provided a glimmer of hope. Intensive lobbying at the national level at a time when issues of population, poverty and development were being reopened globally, could bring about change. There was considerable evidence of internal debate between women's health advocates and population control lobbies within international organisations. Reproductive rights and reproductive health became central to the debate.

Within India, efforts to bring together women's groups, advocates of primary health care, demographers, family planning groups, environmentalists and other concerned activists started in 1993. The initial reaction was one of mutual suspicion. Some women's groups refused to coordinate regional consultations if they were funded and supported by donor agencies known for their 'population control' agenda while others refused to come together with 'family planning *wallahs*'. The more

establishment-friendly groups were apprehensive about sharing a platform with women activists who were perceived as shrill and unreasonable. Many civil servants expressed cynicism about the success of efforts to initiate dialogue between traditional adversaries. In short, many key players felt it was a waste of time and effort.

With hesitation and apprehension the first group of people met to talk about the Cairo Draft Programme of Action and its relevance for India. This meeting turned into a forum to ventilate feelings about the family planning programme and the Cairo document was barely touched! At one meeting the inter-linkages between population, development, poverty, and so on, were not even addressed and the discussion only centered around the immediate health problems of the people. At the other end of the spectrum, another meeting turned into a vitriolic attack on India's population control policy. In all, 18 meetings were organised by one group as preparatory activities for the ICPD conference. Simultaneously, women's groups in different parts of the country organised their own meetings to talk about the Cairo agenda and whether it had any relevance to India. Existing health networks like Medico Friends Circle and the Voluntary Health Association of India initiated their own consultative process.

About the ICPD itself, the national and international media—especially the electronic media—played up the abortion issue. Cairo promised to be a grand entertainer. Yet, despite the skewed publicity and sensational stories, the Cairo conference became a turning point. The entire debate centered around woman's control over her own body, her right to say 'no' and 'enough'. Abortion, invasive contraceptive technologies, male responsibility, right to be treated with respect and dignity, rights of people within unconventional relationships, family reunification rights, forced migration—all these issues turned Cairo into a women's conference.

Reproductive health emerged as the new panacea for all problems. Demographers, family planning service providers, women's organisations, advocates of women's health, donor agencies and the government saw in the phrase 'Reproductive Health' an opportunity to do what they wanted—without attracting too much attention.

- Government saw in reproductive health a new label, a new slogan to merge safe motherhood programme with family planning—and added Reproductive Tract Infection and STDs into the mixture.
- Some donor agencies saw this as a good opportunity to call for a more decentralised effort to integrate maternal and child health with some additions like sexually transmitted diseases and spacing methods. Other donors saw this as an opportunity to step up contraceptive services towards accelerating fertility decline, without the stigma of the earlier FP programme.
- Family planning service providers saw it as an opportunity to continue doing what they have been, after adding some women's sexual health issues such as RTIs and STDs.
- Women activists saw in reproductive health an entry point to bring centre-stage issues of women's status, autonomy, sexuality, violence and human rights.
- Women's health advocates saw a flicker of hope of moving away from the dominant perception of women as baby producing machines to human beings

who go through a life-cycle of deprivation and ill-health.

- Health groups saw this as yet another vertical programme that deflected attention from holistic, good quality, primary health care. Yet they were pleased that women's health would at last get the attention it merited.
- Adult educators saw a great entry point to promote education of adolescents; and
- The HIV/AIDS lobby was pleased that sexuality and sexual health would finally receive attention.

Almost everyone felt they had something special and new in this catch-all phrase. Most importantly, it provided the much needed space to talk about sex, sexuality, male responsibility, public and private behaviour, autonomy, violence and a host of related issues. It could mean different things to different people and that is the trap! The word 'empowerment' lost its meaning after it was popularised in the development world. It soon replaced words like enable, develop, increase, enhance, aware and so on. One poster screamed: 'Empowering women to breast-feed!!!!'—an irony in India where the majority of women not only breast-feed but, in the absence of food, mothers continue breastfeeding well after the required period, often harming their own health.

NGOs working across the country had to come to terms with yet another programmatic focus that was well funded. Not all groups working on health were pleased with the new development. A few had pioneered work in the area and were already involved in women's health issues—including sexual health. Some others, working among women, immediately related to the new concept—it was a natural extension of their work which could also attract funds. Such groups are few and far between. One health group working on reproductive health for almost five years—even when it was not fashionable—commented that the new slogan distorted the concept. Anything from traditional FP services to awareness programmes were given a new label. The activist wondered whether the concept of a life-cycle approach to women's health would ever gain legitimacy. "Like the word empowerment—reproductive health will soon become a empty catch-all phrase that really means nothing".

A vast majority of NGOs who were not involved in the family planning debate or in women's health issues were caught unawares. Many of them recognised the importance of keeping in step with global developmental agendas. As a result, we now have groups frantically trying to contact people who can help them adjust their programmes to the new agenda. In a recent meeting of NGOs working in the area of health and family planning, the organisers were surprised at the enthusiasm of many new NGOs who reached out from different corners of the state requesting invitations. A significant number of them were practising doctors or retired civil servants who were planning to enter the arena.

The last 20 years have seen unprecedented growth in registered NGOs. Some government and donor assisted programmes in a few states have led to the sudden spurt of NGOs in the health and family planning sector. A significant number are of intermediary agencies involved in training and networking. An equally significant number is diversifying and moving into this field. Family planning, social marketing

of contraceptives, HIV/AIDS and reproductive health are the new growth areas in the development sector.[2] This is bound to attract the committed and the opportunists—and as in others areas of the economy, supply will influence demand.

The era of globalisation and liberalisation brought with it new NGO enthusiasts. Disillusionment with the public sector and India's own dismal record in providing quality social services to the poor, prompted liberalisation pundits, donor agencies and banks to champion the cause of the private sector. For almost a decade now NGOs have been seen as the magic bullet that would cut through red-tapism, inefficiency and corruption and reach much needed health care services, credit, education and so on to the poor. NGOs were seen as being more efficient and closer to the people. In the wake of the Panchayati Raj Act, their role in galvanising 'women power' was the new path to empowerment. At the heart of the matter was the question of cost-effectiveness and outreach. Large sums of money for social sector programmes were to be channelled through NGOs.

What about the government? How do officials and politicians view NGOs? With the exception of a few die-hard NGO advocates, most government officials are apprehensive about viewing NGOs as a magic solution. given the nature of our political system with its inherent patronage network and loopholes—most officials point out that the non-government sector is not as rosy as it appears. While not doubting the integrity and work of some organisations, they generally view NGOs with suspicion. Proximity to powerful people, dependence on foreign funds and the emergence of a large number of bogus organisations have forced attention on the dangers of 'handing over' social services to them. They see 'honest NGOs' as effective partners in 'service delivery'—as agents or contractors of the government who are cost effective. Given the financial crunch, long-term staff liability and infrastructure costs have become a major problem. NGOs are seen as a via-media whose contracts can be terminated with ease. Most government officials express reservation about involving NGOs in policy-making and programme development. They argue that foreign funded NGOs are not 'independent'—they could be the mouthpieces of their financiers.

It is a rather ironical situation that 'independent' or truly 'voluntary' NGOs are rare. Social movements and membership organisations are 'independent', but most of them are not in the 'development business'. They have played a significant role as advocates for policy change, campaigning against certain projects like big dams. Over the last 50 years the proportion of resources generated by NGOs from the community has gone down significantly and voluntary work has become uncommon. NGOs are almost totally dependent on donors for project grants. Overtly 'political' activities like advocacy, networking, community mobilisation, formation of people's organisations and building pressure groups are supported as projects. Given the changing international scenario, donor priorities change every few years. NGOs have learnt to adapt to changing international funding priorities, moving when the donors move. With the exception of membership-based organisations and those that mobilise funds from the public, the proportion of foreign funds have gone up by leaps and bounds in the last 20 years. Recalling an old African proverb a commenta-

tor observed "If you have your hand in another man's pocket, you must move when he moves".[3]

Despite inherent contradictions and conflicts, working among the poor requires commitment. Salary scales are rather low in most agencies. Bare subsistence wages, long working hours, absence of job security, health care benefits and provident fund coupled with almost no career advancement for field workers and local employees has set this sector apart from the rest of the economy. In backward areas the local NGO is often the only employer. There have been innumerable heroic tales about dedicated workers and organisations. Alongside, there have been many incidents of corruption, exploitation, refusal to pay minimum wages, sexual harassment and family control. Over the last 20 years 'development' has become a viable career option. Increasing profesionalisation of the sector attracts a new breed of people to it. It has also become a stepping stone to international donor agencies, multilateral banks and the UN system.

The changed environment has encouraged many national and international NGOs to pay competitive salaries and provide a corporate working environment. NGOs today span a wide range—from those working in a small area among the people to intermediary agencies operating at a global level. There is little in common between the two, yet they are clubbed together as NGOs. Unfortunately, it is the professionally managed agencies that are growing. Small groups working in difficult circumstances have had to align themselves with a powerful big brother, an important network, a broker/agent of donors or become the exclusive 'find' of a donor agency.

What is the impact of all this? NGOs today are under tremendous pressure to become service providers over a wide territory. In order to do so, they have to either form networks or expand their scale of operation. Their unique ability to be in touch with the people and respond to their needs is dependent on their proximity to the ground. Territorial expansion coupled with diversification into multiple sectors in order to survive frequent change in donor priorities have robbed many NGOs of their unique selling proposition—accountability, quality, cost-effectiveness and closeness to ground realities. They are also prey to the danger of being over-funded. As 'success' is measured by size and scale, they gradually become big and hierarchical. The stakes increase rapidly. Having employed so many people, organisational heads are forever busy generating resources to maintain their staff. Power, scale, organisational assets, visibility, take over—organisational heads are increasingly alienated from the people. Finally, they become incapable of working towards genuine 'empowerment' of the people and slip into the role of a service provider.

What comes next? Reflecting on the trap they are in, a respected NGO leader known for his personal commitment and incorruptibility said that the only way out is to encourage the formation of membership based people's organisations (popularly known as community based organisations, or CBOs) that would struggle for justice, equity and genuine empowerment. "Acquisition of organisational assets, creating infrastructure and staff liability", he said, "is a trap. Once you are in it you cannot get out. We are now accountable to donors for every penny we receive. All my time

is spent filling out innumerable forms, hosting evaluations and reviews. As they change their priorities, we have to learn new buzz-words and submit new proposals. Today every donor wants to support savings and credit or reproductive health. What option do I have? If I do not change with the times, how will I support 200 families who are dependent on my organisation for livelihood. In a backward region like ours, I cannot shrug my responsibility".

'This dependency syndrome was created by us. I can personally move out and another colleague could run the show but this will not change anything—the show must go on. We are linked to the global market now—I am no longer an independent player, I am a contractor. A development contractor who can either accept and move with the times or opt out. My choices have not been widened—they have shrunk. This is globalisation".

Commenting on the changing nature of NGOs and pulls and pressures faced by them, Edwards and Hulme observed that with the disappearance of voluntarism, NGOs are increasingly being seen as contract agents or as the private sector in the development business. From being partners they are today viewed as contractors and the people whom they serve have been transformed from being a beneficiary to a consumer. NGOs have little choice.

What does this do to accountability systems and internal democracy? Talking about the early years of struggle, most NGO leaders agree that their organisations were far more democratic when they struggled to survive. There was a sense of togetherness. Many of them sacrificed personal comforts and family life. As organisations grew in size, the personal factor was diluted and gradually the iron law of oligarchy asserted itself. Comrades and fellow-travellers (except for the original group) gave way to employees hired for a specific task—it became a job.

The gap between the middle class urban professionals and the field workers increased. Many organisations became extensions of the leader's personality—leading to splits, resignations and expulsions. The leader's ability to mobilise funds, network with donors, government officials and politicians placed him/her above the rest. Survival demanded aggressive networking, publicity and establishing national and international contacts. Gradually, survival became the key issue. This was not all. Some organisations became family enterprises, with leadership passing from parent to offspring. Organisational assets, patronage networks and power became an end in itself. Leaders became power centres in themselves—moving out of their area to establish patronage networks in other areas. In the absence of any objective criteria for assessing capabilities, donors started working through such established middlemen.

The development world is a microcosm of the society we live in. It mirrors the general decline in the moral fabric of our times. With shrinking resources in the last 15 years, competition among NGOs became fierce. Accountability, commitment and proximity to the people became a rare quality. Widespread cynicism about NGOs, especially in an era of globalisation, is understandable. Notwithstanding the dismal picture, it is significant to note that despite erosion of fundamental values, there are many organisations and groups that remain steadfast and continue to make a difference.

In the ultimate analysis, development is about people and expanding the range of choices and enhancing their capability to negotiate this hostile world from a position of strength. Change agents and development professionals have the power to make a difference. Recognising this power and using it to the best advantage of the poor and the marginalised makes a true leader humble. As Robert Chambers puts it:

Development professionals have more power to change the world for the better that is normally realised. To grasp and use that power requires questioning conventional concepts and realities, exploring and embracing a new paradigm, adopting a new professionalism, empowering the poor to analyze and express their reality, and then putting that reality first. . .

Professionals, whether in NGOs, government departments, training institutes and universities or donor agencies, have been slow to see that the fine words of 'partnership', 'ownership' and 'empowerment' by and for the poor, demand institutional change 'by us'. Participation 'by them' will not be sustainable or strong unless we too are participatory. 'Ownership' by them means non-ownership by us. Empowerment for them means disempowerment for us. In consequence, management cultures, styles of personal interaction and procedures all have to change'.[4]

Change is hard to come by, but the value of the few lotuses that flower and grow out of the murky pond gives us reason to hope and to smile.

Notes and References

1. Edwards and Hulme (1996), "Too Close for Comfort?: The Impact of Official Aid on Non-Governmental Organisations", *World Development*, 24, (6).
2. It may be recalled that the eighties saw a sudden spurt of organisations wanting to work with women, indeed even die-hard male bastions sudeenly discovered women. This was a mixed blessing: it gave a tremendous boost to the women's movement, yet at another level, women's development and, later, women's empowerment were trivialised. Similarly the seventies saw a spurt in agencies involved in Adult Education. This was triggered by the National Adult Education Programme, an exclusive NGO support scheme of the government. Again, as in the earlier example, some exceptionally creative work was done but, by and large, the vast majority was of indifferent quality.
3. Proverb quoted by van der Heijden in Edwards and Hulme, *op. cit.*
4. Robert Chambers (1995), "Poverty and Livelihoods: Whose Reality Counts?", *Environment and Urbanisation*, 7, (1), April.

Reproductive Tract Infections—Analysis of Data from Studies Conducted at Maulana Azad Medical College, New Delhi

REVA TRIPATHI

Reproductive Tract Infections (RTIs) have come into the limelight in the past few years since the HIV/AIDS scare. The inclusion of the concept of reproductive health (RH) at the Cairo conference in 1994 gave a further impetus to this disease entity. It has assumed importance for us in India because, amongst the recommendations of the Cairo conference that the Government of India plans to implement on a nationwide scale, is the prevention and treatment of RTI.

The purpose of this paper is to examine whether the inclusion of this problem of RTI in the national programme by the government is really called for.

Ideally, before incorporating any intervention into the already existing health care programmes, the necessity for that particular intervention should be established. Hence, one should be able to answer the question whether RTI is a major problem in India and if so, what is the magnitude of the problem. It is only then that an informed decision should be taken whether RTI is an issue to be dealt with at the primary health care level. In this context the studies conducted in the Department of Obstetrics and Gynaecology, Skin and Venereology and Microbiology at the Maulana Azad Medical College, New Delhi, were reviewed so that some conclusion may be arrived at.

Post-abortal and Puerperal Infections

Studies done in the early sixties showed a high incidence (16 per cent) of puerperal sepsis even amongst hospital deliveries but a decade later the incidence had decreased to 2.05 per cent. Microbiological studies of puerperal cases revealed that the incidence of positive culture decreases in ascending genital tract locations. The incidence of post-abortal sepsis was much higher and was found in the range of 24-44 per cent and maternal mortality due to septic abortions was 6.06 per cent.

More than half the cases of pelvic inflammatory disease that were studied in 1970 were found to be associated with a prior incidence of delivery or abortion or surgical manipulation. This aspect of RTI has, however, not been addressed in studies conducted over the past two decades.

Tuberculosis

Tuberculosis was studied in the seventies when 3.5 per cent of infertility cases were found to show evidence of the disease and only 1.8 per cent of cases of PID were positive by endometrial biopsy.

A recent study in 1995 showed TB to be positive by Elisa in 20 per cent of cases and 22 per cent of patients had laparsocopic findings 'suggestive' of TB. It must be emphasised that these are all presumptive diagnosis and proof by culture or histopathology is lacking.

Chlamydia

Chlamydial infection is the subject of two studies conducted in 1990 and 1992. The studies revealed no statistically significant difference in results between symptomatic and asymptomatic females. Out of a variety of tests conducted only 5 per cent show all tests positive. In cases of vaginal discharge among pregnant women, there was no statistically significant correlation between positive and negative groups. The only significant finding was high incidence of chlamydial infections with cases of infertility having tubal factor as the presumptive cause.

STD

Data on STD is mainly from the STD department and not the gynaecology department. The male-female ratio is extremely high and has been quoted as follows:

	Male-female ratio	*Year*
Gonococcus	19:1	1985
Donovanosis	22:1	1986
Chancroid	22:1	1995
Genital warts	3.8:1	1986

Most men have given a history of extra-marital sexual contact while the few women in whom STD could be demonstrated were either commercial sex workers or partners of these men.

The incidence of various STDs from STD clinic is as follows:

	Percentage	*Year*
Gonorrhoea	10.8	1985
Donovanosis	5.8	1986
	3.14	1993
Chancroid	4.00	1995
Genital warts	9.6	1986

Vaginal discharge

Many studies on vaginal discharge have been conducted between 1962 and 1995 from the department of obstetrics and gynaecology, skin and VD and microbiology. The emphasis has differed in the different studies depending on the department where the study was conducted. The results have been very variable and have indicated that almost 20 per cent patients present with vaginal discharge as the chief complaint in the gynaecology out-patients. Of these only half to two thirds are found to be clinically abnormal and pathological confirmation is arrived at in about one quarter of those who are clinically abnormal. Further questions on what has been the role of therapeutic interventions on these incidences have not been assessed.

A critical analysis of these studies is called for because these and other similar studies are conducted at various tertiary care level institutions and the data so acquired is presented in various fora. The study outcomes are then used to form the basis of interventional strategies. It is therefore imperative that before such strategies are planned, the studies are properly evaluated methodologically and epidemiologically. This will help to ensure that before the results are really accepted as valid, various lacunae and variables have been identified and then depending on the extent of these, relative importance is assigned to the study.

A few critical comments on the studies reviewed here are called for. It is to be noted that often the study was not well planned and the specific objective of the study was not made clear. Hence establishing cause and effect relationships may not be actually possible. The sample size was frequently small and the allocation of patients to various groups was not always randomised. Most of the studies were conducted by post-graduate students (though under the guidance of a supervisor) with various limitations of time, facilities, experience etc. The emphasis of the study differed depending on the department from which it originated thus giving it a subject bias. A glaring lacunae was that though all these studies were on some aspects of RTI, their association with contraceptive usage was not included.

It also appears that if post-abortal and puerperal infection are taken care of, a major proportion of RTI would have been covered. The extent of tuberculosis as a cause of RTI is not known and needs to be further evaluated. With the socio-cultural norms prevailing in India, STD do not appear to be a major contributor to RTI, but with increasing urbanisation and western influence, this may also undergo a change. Studies at various levels (both medical and social) must be conducted to document these changes before an informed decision can be taken as to which aspect of RTI need to be emphasised.

In conducting such studies, the study must be well planned at its inception as the importance of a prospective study is obviously much more than a retrospective one. There must be clear objectives for conducting the study and then appropriate and relevant data must be collected. The number of cases must be adequate if the results are to be extrapolated in a larger context and patients must have clearly defined inclusion and exclusion criteria. If a study is being conducted to prove or disprove a hypothesis, use of the appropriate recommended laboratory tests or procedures must be made and not those which are already considered to have low

sensitivity and specificity. All studies must have been analysed statistically because numbers alone are insufficient.

It is preferable if the data collected is fed into a computerised database from which retrieval is also easier. Adequate financial aid is essential if these studies are to be meaningful because otherwise if suboptimal techniques are used, the study outcomes will also be of correspondingly poor value. It is not necessary to extrapolate all western studies to India but consideration of local context must be kept in mind without compromising the quality of the study undertaken. Indigenous modifications of western methodology should be encouraged. For all this to succeed the study must be conducted by motivated personnel who can devote time to produce quality material. Community based studies must be encouraged because hospital based studies will necessarily show skewed outcomes. Importance must also be paid to interpretation of data and whether the specific cause and effect relationship necessarily holds good should be evaluated before assigning meanings that need not necessarily be precise.

In conclusion it must be clearly emphasised that studies that are presented must be objectively appraised regarding their validity before those study findings can be used to plan strategies which have far reaching implications in the Indian health care delivery system. In our country with an already overburdened economy inflicted with a major resource crunch, it is imperative to have cost benefit analysis performed prior to initiating any intervention regardless of the source recommending them. In addition, western concepts have to be modified and made acceptable within the Indian socio-economic milieu especially in a field such as RTI which has major locally prevalent moderating factors.

Work and Reproductive Health: A Hobson's Choice for Indian Women?

PADMINI SWAMINATHAN

Introduction

We begin with the question raised by Dixon-Mueller in her work on population policy and women's rights,[1] namely, to what extent might the exercise of women's rights in employment contribute to greater sexual and reproductive choice? To those who are convinced that high fertility stems largely from women's subordination and oppression consequent to their exclusion from economically productive labour outside the home, the implications for (development) policy would be clear and straightforward; enlarging women's role outside the family and ensuring equal pay, would, besides conferring positive benefits like raising household incomes, also achieve the prime demographic goal of reducing birth rates. The observed statistical correlation between increase in women's outside employment and decrease in birth rates has catapulted the demand for increasing women's wage employment as a primary goal, not necessarily on its own merits, but as a part of the demographic drive to reduce fertility.

Our interest in the nature of women's work is not merely to record (a la demographers) which kinds of employment are likely to have the greatest impact on fertility. On the contrary, the purpose of our research is to examine at what costs to women's well being (particularly in terms of their physical health) such demographic outcomes occur. We prefer to use the term work rather than just employment since the latter carries the connotation of wage earnings thereby excluding the backbreaking, endless drudgery of domestic and survival tasks (like fetching water and fuel). The relentless application of sheer physical labour to such tasks (that could have been made so much easier with access to simple equipment and basic facilities) takes a heavy toll of the health of the poor, particularly women and children.

The recent reproductive and child health (RCH) programme approaches the problem more from the supply side with accent on quality of care, access to service, coverage of the relevant population etc. We do not discount the need for either strengthening the existing services, making it more accessible and/or broad-based. The burden of our argument is however different: even assuming the programme (RCH) is able to provide the best of services with the widest possible coverage, our contention is that we would still be tackling only 50 percent of the problem of reproductive health. What the programme does not address is the existing structural

nature of women's work (domestic as well as non-domestic) which has severe built in hazards for women's health (reproductive and otherwise) which no amount of first rate quality of care and/or access to health services alone can deal with. Such supply side responses can only mitigate the adverse consequences of work; they cannot address the fundamental causes of these health problems.

We still have a long way to go in developing analytical frameworks that can contextualise simultaneously the social, economic and cultural conditions that force women to 'choose' a particular option over the other possibilities that could have been pursued. Such conditions prevail in a range of situations curtailing reproductive and other choices. For example, since employment options and/or opportunities for skill acquisition and job mobility available to women shrink as we go down the caste and class ladder (and relative to males at each stage of the ladder), women are forced to knowingly expose themselves to reproductively hazardous tasks in the workplace in their desperation to earn a wage income. Similarly the cultural stubbornness of patriarchal households, whatever be the economic contribution of women, forces women to 'choose' abortion (rather than contraceptives) as a means to end unwanted pregnancies and/or as a method of sex selection. The hypothesis that contends that income generating employment outside the home could contribute to greater sexual and reproductive autonomy is hardly applicable to the work that most girls and women do in the third world, particularly in the agrarian settings where they are concentrated. In the Indian context of both economic stratification and social hierarchy, the question whether work is the prime mover of women's status (and therefore their ability to exercise reproductive choices, for example) is pregnant with multiple qualifications and diverse outcomes not only between regions but also between different communities and sections of the population within a region. To quote Kalpana Bardhan:

> The rate of workforce participation may have a role in determining women's status, but that role is qualified by questions of work quality, the class variation in the double burden, and whether productive labour is a sufficient condition for autonomy and voice, whether it is even a necessary condition in a class-and-hierarchy ridden society. Aside from these components of women's status, on which differential work participation may have some intermediate effect, there is the bottom-line component of the value and care accorded to female life.[2]

The absence of ethnographic studies of communities and epidemiological studies linking household structure and the nature of domestic and outside employment to health, makes it almost impossible to establish any causality between work (as we have defined it) and to observed mortality and morbidity indicators. Nonetheless, putting together available information does give a picture, however crude, of the long road still required to be traversed to attain the goal of making women's lives reproductively safe.

In an earlier study dealing with the phenomenon of fertility decline in Tamil Nadu during the decade of the eighties, we had questioned and critiqued the basis for the reasons offered as explanations for the decline in fertility rates.[3] In this paper,

apart from a general discussion on women's outside work, we also delve deeper into a disaggregated analysis of the structure of employment of women in Tamil Nadu; employment here refers to the Indian Census categories of main plus marginal workers. This discussion on Tamil Nadu is primarily to emphasise the fact that a demographically developed state need not necessarily be a reproductively safe place for women. We have supplemented employment data with information relating to the availability/non-availability of basic amenities, like fuel, drinking water and sanitation. The latter is to give an idea of the circumstances under which domestic tasks are carried out.

The first part of this paper focusses on employment, the attempt being to bring together available data, at a disaggregated level, on the structure of women's work outside the home. This data is supplemented with available information on child mortality indicators, the latter being used as a proxy indicator for reproductive health. The second part of the study focusses on the domestic nature of work in general, documenting, in the process, the adverse health consequences of inadequate or almost negligible investment in basic infrastructure (like fuel, drinking water) particularly in the rural areas. The third part concludes with a discussion of the emerging trends in employment as evidenced by recent NSSA data, and, the not-so-encouraging scenario as far as alleviation of domestic drudgery is concerned.

I

Much detailed and painstaking work has gone into unravelling the 'statistical purdah' imposed by existing concepts and methods for measuring labour force participation to make visible the vital and productive work done by women particularly in the rural areas. The official 1981 Census shows only 16 per cent of the rural working-age female population as economically active, compared to 53 per cent for males. But more careful data collection procedures and more inclusive definitions of economic activity result in much higher female participation rates. For example, when women who work part time or those whose main activity is collecting fuel and fodder, or working in dairy, poultry or kitchen garden production for the family are added to those in the conventionally defined labour force, the female labour force participation rate rises to 51 per cent—only 13 percentage points below the male participation rate (Table 1).

We do not wish to enter the debate on the visibility/invisibility of women's work. Our main purpose, on the contrary, is to assess the quality of even this small portion of the female population designated as workers by official data sources. This exercise is not only to highlight the fact that the country invests far less in its women workers than in its working men, but more important, to bring out the complete dissociation between the assumptions and expectations of the new economic policies (namely rapid economic growth, particularly industrial growth and consequent beneficial impact on the population), and the actual ground realities (given the existing level of literacy, level of skill and employment composition of the population).

Table-1: Male and Female Labour Force Participation Rates

(By different data sources and definitions)

Data Source (Definition)	Male %	Female %
Census, 1981 (Main workers)	53	16
NSS, 1983 (Main workers)	61	29
NSS, 1983 (Main and marginal workers*)	63	39
NSS, 1983 (Main, marginal and code 93** workers)	64	51

Note: * Marginal workers are those who engaged in economically productive activities less than 183 days in the year.

** Code 93 activities include fuel, fodder and water collection and work in dairy, poultry or kitchen garden production for the family.

Source: Bennett, Lynn, "Women, Poverty and Productivity in India", draft circulated to participants in joint World Bank-Planning Commission Workshop on Gender and Poverty in India, December 5-7, 1991, New Delhi (mimeo).

The sectoral break-up of occupation reveals that women make up a substantial portion of the agricultural workforce in India.[4] Agriculture accounts for 37 percent of India's GNP and employs about 70 percent of the working population of the country and almost 84 percent of all economically active women. Although almost all rural women are involved to some extent in agriculture, the nature and extent of their involvement varies widely and is strongly influenced by economic status and the caste and class background of their households.

A feature particularly notable for the decade 1971-1981 is the increase in the ranks of female child labour, especially when at the same time, the incidence of male child labour had gone down in rural areas. Analysing the trends in women's employment for the decade 1971-81, Banerjee has shown that, among other things, the number of girl workers in both rural and urban areas had increased faster in states where the workforce participation rates of women had gone up faster; further, a small part of the increase in female agricultural workforce was accounted for by rural child workers for whom most of the increase in absolute numbers as well as in the proportion was concentrated in agriculture.[5] Composition of the workforce by sex and activity according to the 1991 census is now available and shows an increase in workforce participation rate for women between 1981 and 1991. However, until an age-wise classification of the composition of workforce is made available, it would be premature to gloat over the increased work participation rates for women.

An aspect that we do not explore in this paper is the social and economic implications of the noticeably higher work participation rates among scheduled caste and scheduled tribe populations relative to the total population. Scheduled caste and scheduled tribe women account for nearly half of all the female agricultural labourers, although they make up only about a quarter of India's rural female population.[6]

As a general rule, the southern states have a more visible presence as far as female employment (outside the home) is concerned. In Tamil Nadu, in addition, the general all-India phenomenon of the feminisation of agriculture stands out even more starkly. We begin with a set of data laid out in Appendix (I-IV) which give a picture of the nature of female employment in Tamil Nadu. The tables bring out quite clearly the following:

a. four decades of 'development' notwithstanding, even now almost 80 per cent of female workers in Tamil Nadu as a whole are still confined to the primary sector of the economy; within the primary sector, agricultural labour constitutes the biggest category employing 56 per cent of women workers (Appendix I);
b. the distribution of workers by industrial categories and broad age-groups reveals that, proportionately, the percentage of female workers in the age-group 0-14 years, outnumber the males in the same age-groups in each of the industrial categories (Appendix II);
c. a district-wise analysis of the data reveal that in almost all districts of the state, except two or three, more than 70 per cent of the women and girl children, respectively, work either as agricultural labourers and/or cultivators (Appendix III-IV). This phenomenon has a lot to do with the nature of the cropping pattern in Tamil Nadu. For the state as a whole, the area under paddy is more than 40 per cent of total areas under different crops, while production of paddy exceeds 50 per cent of total crop production;
d. the NSS gives some idea of the break-down of agricultural work by major operations. These data show marked differences in the relative importance of female labour between different operations. Women labour figure prominently in transplantation, weeding and harvesting; in fact they outnumber the males in the casual labour category in the latter two operations, but are relatively less important or play a minor role in others, notably ploughing and non-manual work.[7]

The significance of documenting the heavy concentration of women workers in agriculture, particularly in operations like weeding, transplanting and harvesting, lies in the severe implications it has for women's health in general and possibly for reproductive health in particular. One indicator of the adverse consequences of such work is the relatively high child mortality indicators for an otherwise 'developed'[8] state like Tamil Nadu. In addition, Tamil Nadu has the distinction, according to population studies' experts, of having 'demographically arrived'.[9] In Tables 2 and 3 we reproduce the data compiled by the National Family Health Survey on infant and child mortality estimates for Tamil Nadu, along with the comments made by the Survey on the data. Table 4 gives the estimated child mortality indicators for India, Kerala and Tamil Nadu. Appendix V gives the child mortality estimates, districtwise, from the 1981 census, while Appendix VI gives the child mortality estimates by the occupation of main workers. These data culled from different sources bring out fairly clearly:

a. the relatively high infant mortality in Tamil Nadu, which is closer to the all-

India estimates and way behind Kerala, thereby calling into question Tamil Nadu's status as a socially developed state;

b. the infant mortality indicators are uniformly high in the rural areas and more so in the districts where paddy cultivation dominates;
c. infant mortality indicators are particularly high among agricultural labourers and among manual workers;
d. the mortality indicators are considerably higher for births to scheduled caste women than for births to non-SC/ST women. It may be recalled that a far higher proportion of SC women work as agricultural labourers.

Table-2: Infant and Child Mortality

Neonatal, postneonatal, infant, child and under-five mortality for five year periods preceding the survey by residence, Tamil Nadu, 1992

Years prior to survey	*Neonatal mortality (NM)*	*Postneonatal mortality* (PNM)*	*Infant mortality (1q0)*	*Child mortality (4q1)*	*Under-five mortality (5q0)*
Urban					
0-4 years	41.4	19.8	61.2	3.7	64.7
5-9 years	30.4	28.2	58.6	26.7	83.8
10-14 years	29.2	30.6	59.8	39.6	97.0
Rural					
0-4 years	48.9	22.4	71.4	28.7	98.0
5-9 years	54.2	26.5	80.7	34.5	112.5
10-14 years	59.9	28.6	88.5	56.6	140.1
Total					
0-4 years	46.2	21.5	67.7	20.1	86.5
5-9 years	46.5	27.1	73.5	32.0	103.2
10-14 years	50.2	29.2	79.4	51.0	126.4

Note: *Computed as the difference between the infant and neonatal mortality rates.

Neonatal mortality: the probability of dying in the first month of life;
Postneonatal mortality: the difference between infant and neonatal mortality;
Infant mortality (1q0): the probability of dying before the first birthday
Child mortality (4q1) : the probability of dying between the first and fifth birthday;
Under-five mortality (5q0): the probability of dying before the fifth birthday.

Source: National Family Health Survey, Tamil Nadu, 1992. International Institute for Population Sciences, Bombay, December, 1992, p.128.

Table-3: Infant and Child Mortality by Background Characteristics

Neonatal, postneonatal, infant, child and under-five mortality by selected background characteristics for the 10-year period preceding the survey, Tamil Nadu, 1992

Background characteristics	*Neonatal mortality* (NM)*	*Postneonatal mortality (PNM)*	*Infant mortality (1q0)*	*Child mortality (4q1)*	*Under-five mortality (5q0)*
Residence					
Urban	36.1	23.9	60.0	15.1	74.2
Rural	51.7	24.5	76.2	31.7	105.5
Caste/Tribe					
Scheduled Caste	59.1	30.9	90.0	41.0	127.3
Other (Non-SC/ST)	42.3	22.4	64.8	21.3	84.7

Note: Total includes the mortality experience of scheduled tribes, which is based on fewer than 250 children surviving to the beginning of the age interval and is not shown separately.

*Computed as the difference between the infant and neonatal mortality rates.
Neonatal mortality: the probability of dying in the first month of life;
Postneonatal mortality: the difference between infant and neonatal mortality;
Infant mortality (1q0): the probability of dying before the first birthday
Child mortality (4q1) : the probability of dying between the first and fifth birthday;
Under-five mortality (5q0): the probability of dying before the fifth birthday.

Source: National Family Health Survey, Tamil Nadu, 1992. International Institute for Population Sciences, Bombay, December, 1992, p.128.

Table-4: Estimated Mortality Indicators, 1989: India, Kerala and Tamil Nadu

Mortality Indicators	*India*			*Kerala*			*Tamil Nadu*		
	Rural	*Urban*	*Combined*	*Rural*	*Urban*	*Combined*	*Rural*	*Urban*	*Combined*
Child Death Rate	11.1	7.2	10.3	6.0	6.1	6.1	9.7	6.8	8.7
Infant Mortality Rate	98.0	58.0	91.0	23.0	15.0	21.0	80.0	43.0	68.0
Neonatal Mortality Rate	62.1	31.4	56.4	15.2	9.7	14.2	60.4	29.9	50.1
Postneonatal Mortality Rate	36.4	26.3	34.5	7.6	5.1	7.2	19.6	13.5	17.6
Perinatal Mortality Rate	50.9	31.0	47.2	23.4	21.9	23.1	58.7	43.8	53.8

Note: Number of deaths during the year
Crude Death Rate (CDR) = ------ x 1000
Mid-Year Population

Source: Office of the Registrar General, India, Vital Statistics Division, Sample Registration System, 1989, 1992, pp 73 and 95-159, New Delhi, India

Despite the overall decline in infant and child mortality, one in every 15 children born during the five years before the NFHS died within the first year of life, and one in every 11 children died before reaching age five. Overall, 68 per cent of infant deaths recorded in the NFHS in Tamil Nadu occurred during the first four weeks of life. The corresponding proportion for the period 5-9 years before the survey is 63 per cent, which is the same for the period 10-14 years before the survey. The decline in neonatal mortality during the last 15 years was slower than the decline in postneonatal mortality. Under-five mortality for the state declined considerably during the past 15 years, to 87 per 1,000 live births during the period 0-4 years before the survey. The fairly high infant and child mortality rates in Tamil Nadu suggest that child survival programmes need to be strengthened. As expected, rural areas experience higher infant and child mortality than urban areas. The mortality indicators are considerably higher for births to scheduled caste women than for births to non-SC/ST women.

As already indicated, in the absence of epidemiological studies, we have no basis to establish causality between the nature of women's employment and the resultant impact on reproduction. We are, however, positing this hypothesis for Tamil Nadu based on the results of a field study conducted in a paddy intensive area of rural Maharashtra by Batliwala for the Foundation for Research in Community Health (FRCH), Bombay.[10] Noting that almost 80 per cent of the deaths occurred below the age of one year; and that of this over three-fourths occurred in the neonatal period, that is up to 30 days after birth, the most startling finding of the study was the fact that 40 per cent of all infant deaths occurred in the four monsoon months of July to October, that is, at the height of the agricultural season with rice cultivation operations in full swing.

The study offers the following explanation for the bunching of infant deaths during the particular season:

> It is well known that women alone perform the important, skilled but backbreaking job of transplanting saplings in rice cultivation. This means that every woman—heavily pregnant or otherwise—is squatting on her haunches for hours together. Obstetricians confirm that such physical strain and pressure on the uterus could well trigger off premature labour in the last trimester of pregnancy, not to mention increasing the chances of a still birth.[11]

If the above findings are valid, then we do have a fairly strong hypothesis for Tamil Nadu, linking the inflexibility of the mortality indicators beyond a point, to the nature of women's tasks, especially in the rural areas of Tamil Nadu.

New technology in agriculture and particularly that relating to paddy cultivation has not touched those operations which are performed by women, namely, transplanting and weeding. If anything, green revolution has not only led to intensive cultivation but has also increased the number of times that paddy crop is raised within an agricultural season. We have therefore a scenario, wherein even if there is a decline in numbers employed in agriculture, this does not necessarily apply to female labour in paddy intensive areas. Further, and worse, the technological

modernisation of agriculture has not touched the reproductively hazardous operations performed by women labourers.

Outside of farming, the other (census) industrial categories where women are employed, in significant numbers, are the 'household' and the 'other than household category'—the two together constituting the manufacturing sector. To put it differently and more starkly, a fact that is by now well-known and well-documented, the majority of women employed in the non-farm sector are actually in the growing informal sectors of the economy, working either as labourers and servants or as petty producers and traders. Apart from their work being extremely heavy, time consuming and poorly paid, it is also the most deprived in technology and capital inputs. Technological marginalisation of female work is endemic in both agriculture and the non-agricultural informal sectors and accounts partly for the gender gap in wage rates.

The Shramshakti[12] (*Report of the National Commission on Self-employed Women and Women in the Informal Sector*), has documented some of the known health hazards in various occupations in which women in the informal sector are involved (for some details see Appendix VII). It is presently not possible to identify an adequate data base to establish whether women are more or less vulnerable than men to hazards at the workplace. It seems unlikely that there would be biological equality but from a practical point of view it may be that the concept of differential vulnerability is specious for optimal formulation of social policy. This point needs to be underscored since, all over, the concern for the foetus is primarily voiced in those higher paying industries where women have only recently got their 'feet at the door'.[13] When we look beyond these 'non-traditional' jobs, however, concern for real reproductive hazards affecting women workers is markedly absent.

This discrepancy in terms of where women work has a long history. The device of 'protecting' women workers from occupational hazards by excluding them is applied selectively: women in higher paying, 'heavy' industrial jobs get protected out of those jobs, while women in lower paying traditionally 'female sectors' get no protection from serious and pervasive risks.

Quite a few employers have excluded women workers from hazardous jobs based upon the possibility of reproductive injury, while at the same time, they have continued to employ men in jobs which expose them to hazardous substances in excess of accepted legal standards. Thus, on the one hand, they are singling out women, based upon protective health measures while, on the other hand, they are subjecting men to health risks in violation of legal standards. This double-edged position raises serious questions of discrimination against both sexes. From one point of view, women are denied employment; from another point of view, men are denied protection.

The *Report of the Working Group on Personnel Policies* to bring greater involvement of women in science and technology,[14] carried forward the theory of selective sex protection when it recommended thus:

> Promoting the employment of women in science based industries is important. Care is however necessary to see that they are not employed in occupations and activities which have special hazards for them. Women have been found to

> be more prone to some adverse effects, for instance, as in atomic energy and in a mining operations. The Group, therefore, recommends that women should not be put in hazardous occupations or professions where they are biologically not suited. Nevertheless science should offer a variety of occupations and professions which are safe and compatible within family responsibilities. Such occupations could, for instance, be in the fields of Electronics, Food Processing, agricultural operations, Computer Science, architecture, draughtsmanship, etc.[15]

While acknowledging the existing gender bias in declaring certain occupations as reproductively hazardous while leaving out a whole host of others, what needs to be, however, emphasised is the fact that:

a. hazards to reproduction in the workplace are real and need to be addressed. What is being contested is the almost exclusive focus on female reproductive function and the implications for reproductive freedom;
b. protecting only women achieves only part of the goal or 'safeguarding the species'. Male reproductive function is vulnerable too—and vulnerable to the same agents. Yet, there is a remarkable paucity of research on the effects of workplace hazards on male reproductive function, "although there are positive findings virtually every time the question is posed."[16]

II

Universally, two jobs that are carried out almost exclusively by women are housekeeping and child rearing. The possible adverse consequences of these tasks relate principally to the fatigue resulting from long hours of domestic labour and the constant demands of children. There is hardly any documentation, that we know of, of the reproductive impact of long hours of domestic labour including child rearing in the Indian context, but research carried out in industrialised countries estimates that a housewife with a young child works between 70 and 80 hours a week not counting the extra work and sleepless nights when the child is ill.[17] The internalisation of domestic work fatigue is so complete even in developed countries that neither the individuals concerned nor the system can accommodate a demand (if ever it is made) for the right to rest. But the crucial point here is that excessive fatigue is one important risk factor for prematurity.

Theoretically, at least, in the West, pregnant women who have a paid job have the legal right to have their work burden lightened and eventually interrupted without losing their rights as workers. But, even in such societies there is no legal protection for housewives, nor any regulation or risk prevention for the domestic work which all women do—often full time—with a workload that no union in the industrialised world would accept.

> Domestic work represents a danger for the pregnant women and her baby. All the requisite knowledge is to hand. The fact that it is largely ignored demonstrates that the definition of risk factors is not the objective mental exercise that technicians would have us believe, but that it has ideological and political

implications. It is the inability to see domestic work and the rearing of children as real jobs and not as instinctive female functions, that allows the risks, the fatigue and the inherent injustice of the situation to be ignored.[18]

Coming to the Indian scenario, if we expand the definition of work to include the time and energy expanded in basic survival tasks we get a formidable picture of the reproductively hazardous lives being lived by most of our rural women, including in demographic model states such as Tamil Nadu. We dwell below at some length on the domestic chore of fuel collection as an illustration of,

a. the physically depreciating labour that needs to be continuously expended in such tasks in addition to wage earning employment, for sheer survival;
b. the technological exclusion and/or inappropriateness that is the hallmark of the planning process in this sector, and
c. the consequences for health because of the criminal negligence of this sector.

The Gendered Politics of Fuel in India

An offshoot of the adoption of (western) development paradigm has been an extraordinary high growth of population in urban areas. The urban/industrial growth patterns combined with the economic and political clout exercised by the urban elite in demanding priority access to all forms of infrastructure, including supply of energy, has resulted in huge investments in concentrated energy forms serving a relatively small proportion of the nation's population. International and even national aid agencies have been influenced by western patterns of energy supply and consequently have tended to confine their energy capital loans to centralised electricity production and distribution systems.

The above confluence of factors have had an obvious and deleterious impact in that the rural areas have not received a share of investment in energy supply (neither electric nor non-electric) proportionate to the population living there. This scenario, after four and a half decades of planning, is, in fact a documentation of how this pattern of development has excluded vast sections of the population from its purview. This exclusion which is economic in nature for some sections of the urban population, is, for the majority in the rural areas, both at the social and economic levels.

The burden of our argument is that the review of policies, and, attempts at intervention to increase energy supply to the rural areas, cannot be measured simply by citing numbers or quantum of installation of particular facilities (which is what the Plan documents of the States and the Centre do). Despite the increase in the quantum of energy supplied by various components to the rural sector, a vast section of the population, for various reasons, has not benefited, particularly as far as energy for cooking is concerned. A vast majority of these sections of the population which depend almost exclusively on woodfuel systems largely continue to remain both outside the control of government and outside the market economy.

The entire approach towards provision of even basic facilities to this sector has a charity-oriented, social service attitude and not one of the legitimate rights of this sector to a larger share in investment and facilities, given the larger share of population residing in rural as compared to the urban areas. Much of the debate on household

energy requirements has become so engendered that, intentionally or otherwise, the issue of cooking energy and firewood availability has been relegated to the realm of women's issues and therefore of peripheral importance. Much of the discussion on woodfuel crises takes place as part of the larger concern for environmental protection; the fundamental question of how these sections of the population are to survive in the absence of alternative sources of energy gets short shrift in the process.

The most direct and regressive impact of cooking energy non-availability and shortage is on women who are mainly responsible for meeting both basic needs and household energy needs. Time allocation studies document the impact on women's time of fuelwood and fodder shortage. These studies show a wide range (from 45 minutes to 5 hours) in the time women spend each day in fuel collection depending on factors such as proximity to forests or to other sources of fuel, type of farming systems, hill, desert and/or plain regions, etc.[19] The problem of measurement of fuel collection notwithstanding, the important fallout of any increase in fuel collection time is that it has severe implications for other household activities.[20]

More direct linkages exist between fuel shortages and nutrition. Studies have noted that gathering firewood, fetching water, cooking and other domestic tasks account for a substantial share of women's and children's energy output, around 700 and 300 calories per day respectively.[21]

> Domestic drudgery resulting from a lack of public investment in infrastructure and from a lack of public attention to preserving current sources of water and fuel is frequently seen as a hallmark of poverty rather than a direct from of discrimination against women. When such government inattention is viewed in the light of the disproportionate physical burden it imposes on women, it is difficult not to see women's domestic burden as another manifestation of gender inequality in the political process.[22]

Worse, there is growing evidence of adverse health effects because of high biomass smoke levels. Much of domestic cooking and space heating in rural areas take place in poorly ventilated houses through the use of traditional chulhas, which have low thermal efficiency and high emission factors, all of which combine to produce very high concentration of air pollutants. Four major categories of ill-health have been identified as health risks associated with pollutants from using unprocessed biofuels. These include: (a) respiratory infections in young children; (b) adverse pregnancy outcomes for women exposed during pregnancy; (c) chronic lung disease and associated heart disease in adults; and (d) cancer.[23] With regard to adverse pregnancy outcomes, carbon monoxide emitted in the course of biomass combustion is perceived to be one of the major culprits. Considerable amounts of this undesirable gas has been detected in the bloodstreams of women cooking with biomass in India. Besides, studies conducted in Western India associate a 50 per cent increase in stillbirths to exposures suffered by the region's pregnant women.[24] While a lot more studies are required to allow quantified conclusions with some measure of confidence, much more effort is required to make even a small dent in the direction of Indian energy planning. The latter is still driven (politically and otherwise) by the traditional supply-oriented mentality emphasising the development of power, coal and

hydrocarbons without adequate regard to specific end-uses that determine the demand for these energy sources as well as the social and environment costs of providing these services. In fact, most research in the area of fuel upgradation has preferred to keep the concerns of commercial utility and profitability in mind, rather than keeping those of indoor air pollution. As has been pointed out, "in many ways, the problem of indoor pollution as it exists today is an outward sign of the low value placed on the time and labour women".[25]

Objectively, also, the options available (technological and otherwise) for providing energy services to rural areas are still very limited. As a report by TERI points out, "while aggressive promotion exercises had created a general impression that renewables were the panacea for India's energy problems, the reality is that ambiguities persist in the identification of strengths and limitations of each RET (renewable energy technology). Substantial efforts need to be devoted to a serious assessment of what current RETs are able to achieve and to arrive at a realistic estimate of the potential of these technologies in the overall Indian energy system."[26]

III

We began by positing the possibility of a causal relationship between the structural nature of work (both domestic and non-domestic) particularly for women, and reproductive health as indicated by child mortality estimates. We also emphasised the fact that beyond a point, if we have to make a positive impact on reproductive health, we require not just improved and accessible health services, but focussed interventions of such a high order as to change the parameters of development. One such parameter is the structural nature of women's work which has hardly seen any dramatic changes in all these years.

Taking first the case of women's employment outside the home, we had thus far used the 1981 census data to substantiate some of our arguments. In this concluding section we discuss the (limited) data made available relating to the 1991 census as well as the 50th round of the NSS on employment patterns, for a picture of the emerging scenario in the decade of the 90s.

According to 1991 census, all-India, the total rural workforce in the primary sector over the period 1981 to 1991 has come down from 83.35 per cent to 82.26 per cent. At the same time, the rural female population depending on this sector has increased. The percentage increase in rural employment in the primary sector is 18.73 per cent for males and 42.09 per cent for females. Though the total growth in the primary sector is equal to the growth rate of population, the female workers in the agricultural sector increased substantially, while male workforce witnessed a decline compared to the rate of growth of rural population.[27] The NSS gives an even more disconcerting picture of employment growth in the post-reform period. At first sight the results of the 'large sample' 1993-94 NSS survey seem to support the official claim that the employment content of growth has increased in the process of economic reform. However, beyond the official claim, unravelling the quality and content of the data reveals two significant points.[28]

First, the measured employment growth is highly sensitive to the inclusion/

exclusion of subsidiary workers. During 1990-94 the number of principal workers increased by 18 million, but the number of subsidiary workers increased by 22 million. The latter are persons (overwhelmingly women) who report themselves 'usually not in the work force' but who did some work during the year. It is only if this category is included in the definition of workers that the post-reform employment growth can be said to have been higher than the pre-reform trends.

The second point to note is that even including these subsidiary workers, the recent growth rate of non-agricultural employment decelerated very markedly after the reform. An interesting aspect of this is that the deceleration in the growth of non-agricultural employment was concentrated entirely in rural areas, with there being no sign at all of any significant deceleration of urban employment growth, total or non-agricultural. This reversal, with initiation of reforms, of what had hitherto been a very rapid growth of rural non-agricultural employment is perhaps the most significant result emerging from the survey.

Clearly the post-reform deceleration in non-agricultural employment growth was accompanied by a large relative shift towards agricultural work, and there was also a large increase of subsidiary workers doing such work. This raises the natural question as to whether this increase in agricultural employment was a positive development or a distress outcome related to lower rural non-agricultural opportunities and higher poverty.

In fact, the rate of growth of agricultural output has slowed down after the reforms. Thus the growth of labour demand in agriculture is likely to have decelerated as well. Consequently, what is being observed is almost certainly a rise in labour supply into the agricultural sector from certain segments of the rural population, particularly casual labourers and subsidiary workers. This in itself suggests that the higher growth of agricultural employment was driven more by distress factors: for example, research on female participation rates in the past have concluded that female participation in the casual agricultural labour market and as unpaid helpers in family farm tends to increase in bad years. And more generally, data on agricultural employment shows that per worker agricultural output fell significantly in the post-reform period. This development too confirms that the post-reform increases in agricultural employment took place not in the context of greater rural prosperity but reflected greater adversity.

If the scene on the non-domestic employment front is not very encouraging, the situation in the domestic front, as far as household work is concerned, is not very bright either. To come back to our discussion on the availability of basic infrastructural facilities like fuel, water,[29] etc., we find that, according to the 1991 census,[30] for the country as a whole,

a. only 56 per cent of rural households had access to safe drinking water, that is, water drawn from tap, hand pump/ tube well;
b. only 35 per cent of rural households had access to electricity;
c. only 9 per cent of rural households had access to toilet facilities;
d. while 55 per cent of urban households, other than those of SC/ST, had access to all the three facilities (of drinking water, electricity and toilets), only 5 per

cent of rural households had access to all the three facilities;

e. wood is still the most important fuel for cooking used by 72 per cent of households in the rural areas, followed by cowdung (20 percent).

To complete this dismal scenario we need only to point out the less-than-one-percent of total central plan expenditure put aside for the non-conventional energy sector.[31] This, despite the fact that non-conventional energy sources continue to contribute significantly in meeting the energy needs of the rural areas. Such abject low investment in rural infrastructure has a direct bearing on the health (reproductive and otherwise) of rural women because of the enormous strain they have to undergo for the most basic tasks. In such a context it becomes increasingly problematic to support policies aimed solely at improving women's participation in market activities. Our emphasis, therefore, on modifying and/or doing away with institutionalised inequalities between men and women at the household and societal level is not just to achieve gender justice but also, and more importantly, for gender-safe life and reproduction.

Appendix-I: Distribution (Percent) of Total Workers by Industrial Categories, Sex and Sectors of Economy, 1981

	Industrial Categories	*Persons*	*Males*	*Females*
I	Cultivators	28.78	31.60	22.63
II	Agricultural Labourers	33.51	23.56	55.24
III	Livestock, forestry, fishing etc.	2.48	2.68	2.06
	Mining and Quarrying	0.21	0.24	0.14
IV	Primary Sector:			
(a)	Sub-total	64.98	58.09	80.07
V	Manufacturing, processing, servicing and repairs			
	(i) Household industry	4.82	4.11	6.35
	(ii) Other than household industry	10.09	12.45	4.94
	Construction			
VI	Secondary Sector: Sub-total	1.58	2.03	0.61
(b)	Trade & Commerce	16.49	18.59	11.90
VII	Transport, storage and communications	8.17	10.78	2.46
VIII	Other services	2.98	4.20	0.32
IX	Tertiary sector: Sub-total	7.38	8.35	5.25
(c)		18.53	23.33	8.03

Source: Report and Tables based on 5 per cent sample data Census of India, 1981, Series 20, Tamil Nadu, Part II-Special, Statement 48.

Appendix-II: Distribution (percent) of Workers (Main plus Marginal) by Industrial Categories and Broad Age Groups, 1981 (Tamil Nadu)

Industrial Categories	*Males*			*Females*		
	0-14	*15-59*	*60+*	*0-14*	*15-59*	*60+*
I-IX	3.71	89.12	7.17	7.22	88.14	4.64
Cultivators	2.71	86.00	11.29	5.36	88.73	5.91
Agricultural Labourers	6.74	86.96	6.30	7.51	87.91	4.58
Livestock, forestry, fishing etc.	8.25	86.53	5.22	12.53	85.33	2.14
Mining and Quarrying	3.11	94.94	1.95	12.39	86.89	0.72
Manufacturing, processing, servicing and repairs						
(a) Household Industry	4.23	88.11	7.66	10.00	86.52	3.48
(b) Other than Household Industry	4.32	92.26	3.42	14.59	83.37	2.04
Construction	1.92	92.65	5.43	6.12	90.84	3.04
Trade & Commerce	1.92	92.02	6.06	2.08	88.37	9.55
Transport, Storage and Communication	0.47	97.18	2.34	1.12	96.99	1.89
Other Services	0.76	94.76	4.47	2.65	94.54	2.79

Note: The total of the three broad groups may not add upto 100 as "age not stated" figures are not included in the statement

Source: Computed from the Report and Tables Based on 5 per cent sample data Census of India, 1981, Series 20, Tamil Nadu, Part II-Special, Statement 49.

Appendix-III: Percent of Agricultural Workers to Total Female Workers in Tamil Nadu (Districtwise)

(Rural + Urban)		*(Rural)*	
District	*Agri. Labour+ Cultivators*	*District*	*Agri. Labour+ Cultivators*
Dharmapuri	91.92	Dharmapuri	94.07
South Arcot	91.10	Pudukottai	93.56
Pudukottai	90.98	South Arcot	93.55
Tanjore	87.59	Tanjore	93.30
Trichirapalli	87.47	Trichirapalli	92.88
North Arcot	85.33	North Arcot	91.34
Madurai	82.87	Madurai	90.55
Periyar	79.99	Chengai	88.78
Chengai	78.94	Salem	87.29
Salem	77.76	Coimbatore	86.58
Ramnad	75.62	Ramnad	86.09
Coimbatore	68.31	Periyar	85.69
Tirunelveli	61.16	Tirunelveli	70.54
Kanyakumari	33.69	Kanyakumari	40.82
Nilgiris	9.19	Nilgiris	9.97

Note: Agricultural workers = Agricultural Labourers plus Cultivators
Source: Computed from General Economic Tables, Tamil Nadu, Series 20, Census of India, 1981.

Appendix-IV: Female Agricultural Child Workers (0-14 years), Tamil Nadu (districtwise)

District	*Rural + Urban*					*Rural*				
	Total female child workers (0-14)	*of which*		*Total female agri. labourers + cultivators (0-14)*	*% of col.4 to col.1*	*Total female child workers (0-14)*	*of which*		*Total female agri. labourers + + cultivators (0-14)*	*% of col.9 to col.3*
		female agri. labourers (0-14)	*female cultivators (0-14)*				*female agri. labourers*	*female cultivators (0-14)*		
Madurai	52608	36649	8551	45200	85.92	47218	34438	8334	42772	90.58
South Arcot	34801	24442	6257	30699	88.21	34124	24187	6217	30404	89.10
North Arcot	45041	29111	7531	36642	81.35	41911	28556	7507	36063	86.05
Tanjore	17207	13071	1384	14455	84.01	14954	12624	1339	13963	93.37
Trichirapalli	32660	20689	7633	28322	86.72	30765	20133	7586	27719	90.10
Salem	47079	24307	8763	33070	70.24	39256	23398	8617	32015	81.55
Tirunelveli	45178	14392	3861	18253	40.49	34618	13068	3744	16812	48.56
Ramnad	45271	16153	8907	25060	55.36	36460	15464	8837	24301	66.65
Chengleput	22777	14666	2552	17218	75.59	20193	13777	2460	16237	80.41
Coimbatore	32113	21492	2578	24070	74.95	26237	20200	2503	22703	86.53
Periyar	30102	20566	3288	23854	79.24	27149	19697	3239	22936	84.48
Dharmapuri	30681	18648	10276	28924	94.27	30090	18514	10260	28774	95.63
Pudukottai	10500	5044	4296	9340	88.95	10200	5013	4291	9304	91.22
Kanyakumari	3062	677	47	724	23.64	2527	663	47	710	28.10
Nilgiris	2499	256	50	306	12.24	1764	165	50	215	12.19

Note: Agricultural Workers = Agricultural Labourers plus cultivators

Source: Computed from General Economic Tables, Tamil Nadu, Series 20, Census of India, 1981.

Appendix-V: Child Mortality Estimates, Tamil Nadu

State/District		*q(1)*	*q(2)*	*q(3)*	*q(5)*
Tamil Nadu	Total	86	103	114	132
	Rural	94	116	127	146
	Urban	68	78	88	104
Madras	Urban	53	58	66	79
Chengalpattu	Total	85	102	112	132
	Rural	93	116	125	146
	Urban	85	100	116	129
South Arcot	Total	104	127	143	167
	Rural	109	134	152	177
	Urban	72	85	93	110
Dharmapuri	Total	81	98	106	122
	Rural	83	101	111	125
	Urban	66	77	86	96
Salem	Total	74	88	95	112
	Rural	77	94	101	116
	Urban	65	74	80	101
Periyar	Total	76	94	102	110
	Rural	79	99	106	113
	Urban	70	92	82	102
Coimbatore	Total	76	90	95	113
	Rural	90	111	122	134
	Urban	64	74	81	94
Nilgiri	Total	86	105	113	133
	Rural	94	108	126	153
	Urban	76	93	101	111
Madurai	Total	88	107	118	137
	Rural	100	124	138	156
	Urban	67	78	87	100
Trichirapalli	Total	87	104	118	134
	Rural	92	112	126	140
	Urban	74	84	95	116
Thanjavur	Total	79	95	100	122
	Rural	81	98	104	125
	Urban	73	84	97	112
Pudukottai	Total	73	83	98	111
	Rural	75	86	100	114
	Urban	59	68	76	85
Ramnad	Total	96	118	129	149
	Rural	103	131	142	159
	Urban	78	89	105	123
Tirunelveli	Total	105	128	148	166
	Rural	114	140	163	181
	Urban	89	105	122	139
Kanyakumari	Total	58	68	72	87
	Rural	59	67	73	88
	Urban	58	70	75	80

Note: The four estimates of child mortality, namely q(1), 1(2), q(3), and q(5) denote the number of deaths per 1000 live births by age 1, 2, 3 and 5 respectively.
Source: Child Mortality Estimates of India, Census of India 1981, Occasional Papers, No. 5 of 1988 (pp. 186–88), Office of the Registrar General, New Delhi.

Appendix-VI: Child Mortality Estimates by the Occupation of Main Workers Tamil Nadu

Occupation		*q(1)*	*q(2)*	*q(3)*	*q(5)*
Main Workers	Total	104	135	144	159
	Rural	106	135	146	163
	Urban	92	115	130	135
Cultivators	Rural	92	112	126	142
Agricultural Labourers	Rural	138	143	155	174
Manual Workers	Rural	134	151	157	180
	Urban	138	143	148	167
Non-Manual Workers	Rural	70	85	92	99
	Urban	50	63	64	64
Non-workers	Total	73	85	94	111
	Rural	81	97	106	123
	Urban	63	71	80	96

Note: The four estimates of child mortality, namely, a(1), q(2), q(3), and q(5) denote the number of deaths per 1000 live births by age 1, age 2, age 3 and age 5 respectively.
Source: Child Mortality Estimates of India, Census of India 1981, Occasional Papers, No. 5 of 1988 (p. 192), Office of the Registrar General, New Delhi.

Appendix-VII: Known Health Hazards of Some Occupations

Occupation and some Causal Factors	*Health problems*
Manual Agricultural Workers	**General**
(Postural problems exposure to dusts and chemicals; unguarded implements; working barefoot)	Generalised body ache; aches in calves, hips, back, legs and shoulders; nasal catarrh irritating coughs; irritation of the respiratory system; respiratory tract infections; tightness of chest; chest capacities; pneumoconiosis; cutaneous allergies; skin irritation; paddy keratitis; helminthiasis—schisto-somiasis, anky-lostomiasis; paronocia; fungal infections in feet; eczema; osteomyelitis of fingers.
	Injuries
	High rate of thresher accidents, especially while crushing sugarcane and ginning cotton; also serious physical injuries occur from the cutting edges of implements, such as sickles and machetes; for lack of first aid facilities, small injuries become serious and often lead to tetanus.
	Toxicities
	Pesticide poisoning; intestinal respiratory and neurological disorders; nausea, vomiting; abdominal crumps; diarrhoea; cough; headaches, vertigo; blurred vision; muscular twitching, convulsions; loss of reflexes; loss of sphincter control; disturbance of equilibrium; jaundice; coma, and ultimately, death may result by respiratory arrest.
Plantation Workers	**Gynaec**
(inhalation of dust; exhaustion due to heavy work loads, further increased by piece rated wages & by high environmental temperatures & humidity; lack of health & medical services, working barefoot)	Abortions; premature deaths and stillbirths; high rate of neo-natal, infant and maternal mortality.
	Lung infections and bronchial problems; physical stress; malnutrition; Helminthie infestations; dysentries, contact dermatitis and other contact diseases; heat stroke, high incidence of maternal and child mortality.
Construction workers	
(heavy work load, unsafe noise levels; exposure to dusts and chemicals; accidentprone working	Physical stress and strain; skeletal defects; numbness of hand and fingers; loss of hearing; stress; high blood pressure; muscular pain; intestinal problems; gastroenteritis; respiratory problems; asthma; silicosis;

Carrying Water	
(heavy physical strain, even during pregnancy)	Physical strain; intense pain in different parts of the body, especially the legs, waist, pin bones and shoulders; prolapse of the uterus; miscarriages.
All workers involved in Manual Labour	
(lifting heavy weights; postural problems; heavy workload; continuous heavy work from childhood through illness, pregnancy and in the post-partum period to old age; nutritional deficiency).	Disturbances of blood circulation in the pelvic organis and lower limbs' menstrual disorders; prolapses of the uterus; mis-carriage or still birth; flat and narrow pelvic, if carrying weights from early age; risk of injury to spinal column and adjacent muscles, especially in thelumbar region; circulatory organis may be affected; deformities; callousites; neutric pains; paralysis.
All women workers working in home-based occupations	
(Exposure to dusts, such as tobacco, cement, housedust, exposure to hazardous chemicals, carbon moxonide, lead, abrasive cleaners, fungi; drudgery; repeated movements of a few parts of body; heavy workload; postural problems without respite; constant strain on eyes due to poor lighting; low nutritional status and work valued less in money terms as well as in terms of status.	Respiratory problems; hastening of tumours; digestive problems; adverse effect on reproductive systems; fatigue; skin problems; back, particularly low back pain; pain in limbs; body aches; stiffness of joints; weakening of eye sight; heart diseases; acidity; ulcers, exhaustion and dizziness.
Workers involved in Processing and other industries	
(body exposed to ice-cold water; corrosive fluids; wet grounds; constant exposure to dusts, such as, silica, fibres, allergens; infections due to work; drudgery; eye strain; injuries due to sharp-edged, rough surfaces; contact with extremely hazardous and explosive chemicals; lack of facilities like Toilers, drinking water, rest rooms; low wages and insecurity of employment; low nutritional status.	Extreme fatigue; pain in body; corrosion of hands and feet; peeling of the skin; silicosis and other incurable and fatal respiratory problems such as fibrosis; clubbing of fingers; serious injuries; skin diseases like dermalitis; elephantiasis; backaches; allergies; weakening of eyesight.

Source: Shramshakti Report of the National Commission on self employed women and womenin the informal sector, June 1988, New Delhi.

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2. Baradhan, Kalpana. 1985. "Women's Work, Welfare and Status: Forces of Tradition and Change in India", *Economic and Political Weekly*, vol. 20, nos.51 and 52, December 1921-28, p. 2262.
3. Swaminathan, Padmini. 1996. "The Failures of Success? An Analysis of Tamilnadu's Recent Demographic Experience", Working Paper No. 141, Madras Institute of Development Studies, Chennai, July.
4. For a fairly detailed discussion of the (statistical) aspects relating to women's participation in the labour force, see *Gender and Poverty in India: A World Bank Country Study*, Washington, 1991.
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6. *Gender and Poverty in India*, op. cit.
7. For more details see A. Vaidyanathan, 1986. "Labour Use in Rural India: A Study of Spatial and Temporal Variations", *Economic and Political Weekly*, vol. 21, no. 52, December 27, pp. A130-A146.
8. There is no disputing the fact that Tamil Nadu is one among the leading industrialized states of the country. Several indicators bear this out. Data in terms of share in number of factories, number of employees, value of output and net value added (for the registered manufacturing factory sector) show that Tamil Nadu has remained within the top four states. For more details, see Padmini Swaminathan, "Where are the Entrepreneurs? What the Data Reveal for Tamil Nadu", *Economic and Political Weekly*, vol. 29, no. 22, May 28, 1994, M64-74.
9. See in this context the following:
   (a) Bose, Ashish. 1994. "IN's successful demography transition", *Financial Express*, Madras, January 4.
   (b) Antony, T.V. 1992. "The Family Planning Programme: Lessons from Tamil Nadu's Experience", *The Indian Journal of Social Sciences*, vol. 5, no.3.
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10. Batliwala, Srilatha. 1988. "Fields of Rice: Health Hazards for Women and Unborn Children", *Manushi*, no. 46, pp. 31-35.
11. Ibid, p.34.
12. Shramshakti. Report of the National Commission on Self Employed Women and Women in the Informal Sector (Chairperson: Ela R. Bhatt), June 1988, New Delhi.
13. For an excellent overview on Occupational Health and Women's Work see the following:
   (a) Chavkin, Wendy, 1979. "Occupational Hazards to Reproduction: A Review Essay and Annotated Bibliography", *Feminist Studies*, vol. 5, no. 2, Summer, pp. 310-25.
   (b) Hunt, Vilma, R. 1979. *Work and the Health of Women*, C.R.C. Press, Florida.
   (c) Romito, Patrizia, and Hovelaque, Francoise, 1987. "Changing Approaches in Women's Health: New Insights and New Pitfalls in Parental Preventive Care", *International Journal of Health Services*, vol. 17, no. 2, pp. 241-58.
14. India, Government of. 1981. *Report of the Working Group on Personnel Policies for Bringing Greater Involvement of Women in Science and Technology*, Ministry of Social Welfare, New Delhi.
15. Ibid, p. 8.
16. Chavkin, Wendy. 1979. "Occupational Hazards to Reproduction...", op. cit., p. 313.
17. Romito, Patrizia and Hovelaque, Francoise, 1987. "Changing Approaches in Women's Health...", op.cit., p. 244.

18. Ibid, p. 247.
19. See Tables 45 and 46 in the study on *Gender and Poverty in India,' A World Bank Country Study*, Washington, 1991, pp. 323-24.
20. "There is often a trade-off between the time spent in collecting fuels and the time must be devoted to preparing them and tending the cooking fuel. Major activities related to fuel provision include:
    - travel time to the fuel gathering area;
    - time spent in fuel collection;
    - transporting fuels;
    - fuel preparation (woodcutting, breaking and bundling of crop residues, making dung cakes);
    - procuring kerosene (extremely time-consuming where kerosene is rationed as in many countries);
    - food preparation and cooking; and
    - fire tending.

    Clearly, it is the totality of this labour use versus cost and convenience considerations that is the basis for the household's choice among alternative fuels."

    Cecelski, Elizabeth. 1985. *The Rural Energy Crises, Women's Work and Basic Needs: Perspectives and Approaches to Action*, International Labour Office, Geneva, p. 24.
21. Batliwala, Srilatha, 1982. "Rural Energy Scarcity and Nutrition: A New Perspective", *Economic and Political Weekly*, vol. 18, no. 9, February 27, p. 332.

    Cecelski (1985) adds:

    > Time spent on [these] survival activities can be compressed little without seriously affecting family welfare. Most often when opportunities for women to earn extra income or the need for agricultural work present themselves to a poor family the solutions are limited; the woman works even longer hours; other family members (most often children) take over some of these tasks, reducing other activities such as school attendance, or the less "essential" survival activities—such as hygiene, child feeding and care—and preparation of special infant foods are skipped or abandoned.

    Cecelski, Elizabeth. 1985. The Rural Energy Crisis..., op. cit., p. 30.
22. In an interesting article from where this quote is taken, Sonalde Desai and Devaki Jain argue that in many developing countries women's domestic burdens may pose a greater impediment than child care responsibilities to participation in those economic activities that may yield higher income.

    Desai, Sonalde, and Jain, Devaki, 1994. "Maternal Employment and Changes in Family Dynamics: The Social Context of Women's Work in Rural South India", *Population and Development Review*, vol. 20, no. 1, March, p. 132.
23. These and more details are contained in the following:
    (a) Tata Energy Research Institute, 1994. *Changes in the Indian Energy Scene Over the 70s and 80s*, Second India Study Revisited, New Delhi, February, especially Chapter 11.
    (b) Tata Energy Research Institute, 1995. *Environmental Considerations and Options in Managing India's Long-term Energy Strategy*, New Delhi, November (A Report prepared for the United Nations Environment Programme).
24. A telling analysis of the adverse consequences faced by the Indian poor because of prolonged and intense exposure to pollution within the four walls of homes is contained in, Souparno, Banerjee, 1996. "The Enemy Within", *Down to Earth*, vol. 5, no. 5, July 15, pp. 27-32.

    See also in this context, Batliwala, Srilatha. 1995. "Women and Energy: Bearing the Brunt of Labour", *The Hindu Survey of Environment*, Chennai, pp. 15-20.
25. Jamuna Ramakrishna quoted in Souparno, Banerjee, 1996. "The Enemy Within", op. cit., p. 32.
26. Tata Energy Research Institute. 1994. *Changes in the Indian Energy Scene Over the 70s and 80s*, op. cit., p. 163.

27. For more details, see, Arun Kumar, A.V., Vani, B.P., and Vyasulu, Vinod. 1994. "Structure of Employment as Seen from 1981 and 1991 Censuses: A Preliminary Look", *Economic and Political Weekly*, vol. 30, no. 38, September 23, pp. 2375-88.
28. Points (a) to (d) which follow, draw heavily from an analysis of the NSS data made by C.P.Chandrasekhar and Abhijit Sen, 1996, "Has Employment Really Improved Post-Reforms?", *Business Line*, September 24, Chennai.
29. A study of time, energy and consequences for health of drinking water collection, would without doubt bring out the adverse (reproductive) health impact of non-availability and/or not-so-easy availability of water similar to the problems related to collection of fuel. As an illustration we reproduce a finding published in the *Indian Express*, July 16, 1994, Chennai.

    The need to carry water either over long distances and/or up a flight a stairs (as in the case of urban Housing Board tenements), apart from causing heavy physical strain, is also responsible for prolapse of the uterus and miscarriages. A random survey by Indian Express has revealed that women residing in the City's Slum Clearance Board tenements and multi-storeyed Housing Board apartments in certain water-deficit localities in Madras city are prone to a host of physical debilities and gynaecological complications. Brought about primarily by carrying water up several flights of steep steps many times a day, these women end up with complaints ranging from acute pain in the abdomen and pelvis, disorders in the menstrual cycle and painful swelling of the joints and other complications, at times resulting in displacement of the uterus. Doctors attending on women residing in these localities confirm that such ailments are very common among the women dwelling in the upper floors of tenements.
30. Details contained in, Census of India, 1991, Paper 2 of 1993, *Housing and Amenities; A Brief Analysis of the Housing Tables of 1991 Census*, Office of the Registrar General and Census Commissioner, India, New Delhi.
31. Refer, for example, to *Sectoral Energy Demand in India* Report of the Government of India in cooperation with ESCAP, UNDP and the Government of France, August 1991, p. 32.

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